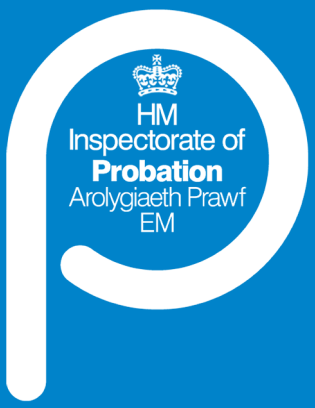

Quality & Impact inspection
The effectiveness of probation work in the north of London

An inspection by HM Inspectorate of Probation

December 2016

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Foreword

This is our first inspection of adult probation services in the capital for some time. It is not yet comprehensive – in that on this occasion we inspected in eight boroughs in the north of London, and will return to inspect other London quadrants next year and beyond. Meanwhile we hope that our findings are of value to those responsible for probation services throughout the city.

Delivering probation services in the capital is particularly challenging. The city has a diverse, mobile and relatively young population, living in 32 boroughs that each differ in the way they work with offenders. The work is unrelenting, with some 17% of all those under probation supervision nationally living in London[1]. Probation services in London have long struggled with high workloads, and workload pressures have been a regular feature in the most notorious of cases where a supervised individual has committed a Serious Further Offence.

We found the quality of work by the Community Rehabilitation Company (CRC) poor. There was some welcome good practice by individual officers and first-line managers but generally, practice was well below standard, with the public exposed unduly to the risk of harm in some cases despite lessons from the past. That is plainly not acceptable.

A combination of unmanageable caseloads, inexperienced officers, extremely poor oversight and a lack of senior management focus and control meant some service users were not seen for weeks or months, and some were lost in the system altogether – something we alerted managers to early on in our inspection. This simple lack of management attention to basic attendance and supervision was the most striking and surprising finding, and again, not acceptable.

Sadly and despite the heroic efforts of some staff, we found that there had been little or no likely impact on reducing reoffending. Staff were sometimes working long hours and were often 'fire-fighting' rather than enabled to deliver a professional service consistently or sufficiently well.

We found the National Probation Service (NPS) delivering services better, but with plenty of room for improvement. The quality of work was mixed, but we were pleased to find that public protection work was satisfactory overall. The delivery of court services has been a rubbing point in the 'new world', and we found it stubbornly problematic here. Managers must resolve tensions between the two organisations, to improve court services.

1 Offender Management Caseload statistics (table 4.10), Ministry of Justice, October 2016.

We will turn again to London next year, and once leaders have had the chance to consider and respond to our recommendations. No doubt CRC leaders and owners are eagerly awaiting the outcome of the government's current Probation Services Review but in our view, basic and much needed improvements in London must commence straightaway.

Dame Glenys Stacey
HM Chief Inspector of Probation
December 2016

Key facts

258,748 The total number of offenders subject to probation supervision across England & Wales[2].

28,750 The number of offenders supervised by the London CRC[2].

47% The proportion of the CRC cases which relate to a custodial sentence (pre or post-release supervision)[3]. The proportion for all England & Wales was 56%.

86.9% The proportion of offenders who were recorded as having successfully completed their period of licence or post-sentence supervision with the CRC[4]. The performance figure for all England & Wales was 74.6%, against a target of 65%.

15,563 The number of offenders supervised by the London division of the NPS[2].

10,071 The number of MAPPA eligible offenders managed by the NPS in London[5].

-12% The volume reduction for the CRC caseload, comparing 2015-2016 annual data to initial assumptions[6]. The reduction across CRCs ranged from -6% to -36%.

2 (of 21) The number of CRCs owned by MTCnovo.

2 Offender Management Caseload Statistics as at 30 June 2016, Ministry of Justice.
3 Offender Management Caseload Statistics as at 30 June 2016, Ministry of Justice.
4 CRC Service Level 9, Community Performance Quarterly Statistics April-June 2016, Ministry of Justice.
5 Multi-Agency Public Protection Arrangements (MAPPA) Annual Report as at 31 March 2016, Ministry of Justice.
6 'Transforming Rehabilitation', National Audit Office, 2016.

1. Overall judgements and recommendations

- Protecting the public
- Reducing reoffending
- Abiding by the sentence
- Recommendations

London probation services were last inspected in 2014, when services were provided by one organisation, the London Probation Trust. Direct comparisons over time cannot be made, as we have since developed our inspection methodology, and in any event probation workloads and work types differed in 2014 (see chapter 2). We summarise the outcomes from our 2014 inspection in the following table:

Outcomes	The proportion of work judged to have been done well enough
Assisting sentencing	85%
Delivering the sentence of the court	67%
Reducing the likelihood of reoffending	53%
Protecting the public by minimising the risk of harm to others	52%
Delivering effective work for victims	53%

Table 1.1. Summary of HMI Probation's inspection findings from the previous inspection in the London area in January 2014.

At that time, sentencers were generally happy with the service provided in courts, but would have liked to have been able to order more reports prepared on the day. Court reports were of a good standard, but there were difficulties obtaining Crown Prosecution Service documentation about the offence.

Contact with individuals was generally prompt after sentence or release, the frequency of appointments was sufficient, and enforcement action was taken appropriately for failure to comply with supervision. Several aspects of practice, however, remained unacceptable: for example, most assessments did not reflect the current circumstances of the people being managed and plans were created without their active involvement. We were particularly concerned that not enough work was done with individuals to address their offending behaviour. These findings were reflected in poor inspection scores in four of our five outcome areas.

Some of these difficulties remain. The full findings from this inspection are summarised in the following chapters.

Protecting the public

CRC effectiveness

Overall, performance was poor. The proportion of work carried out to a sufficient standard did not meet our expectations and was low when compared to our findings to date in other parts of the country.

Assessment, planning and interventions were not carried out well enough. Significant information was not always recognised as such and there was a lack of awareness of domestic abuse and child safeguarding issues.

Individual caseloads varied significantly. Some were, in our view, unreasonable and unmanageable. Low levels of contact with service users, coupled with inadequate systems to monitor the frequency of contact inevitably and materially affected the quality of work to protect the public.

The inexperience of some staff coupled with a lack of management support made this problem more acute in some cases. Senior management appreciation of these difficulties, and plans to resolve them were either absent altogether or else inadequate in our view.

NPS effectiveness

NPS performance was mixed.

Overall, most public protection work was carried out sufficiently well but the quality of assessment, planning and interventions was mixed.

Attention needed to be focused more sharply on public protection and in particular on the formal review of cases, and recognising and responding to significant changes in individuals' circumstances.

The CRC and NPS working together

There were some obvious tensions between the CRC and the NPS. The quality of case allocation forms and risk assessments prepared at court by the NPS was acknowledged to be variable at best and poor at times. Failure by the NPS to provide detailed information caused difficulties for responsible officers in both organisations but particularly in the CRC. The NPS was working hard to improve this but felt that expectations of what could be achieved within the court timescales were unrealistic.

Risk escalation was another area of work that had required ongoing management attention to make sure that relevant cases were escalated and accepted. Efforts were being made to resolve this issue by close liaison between the two organisations.

Reducing reoffending

CRC effectiveness

Overall, performance was poor. The proportion of work carried out to a sufficient standard was low. There was an alarming lack of contact in too many cases: assessments had not been carried out, planning had not taken place and little work to reduce reoffending had been delivered.

Most service users had not received a service that met their needs or was likely to help them to stop reoffending.

NPS effectiveness

Performance in the NPS was mixed. The majority of offending behaviour work was done to an acceptable standard but a noticeable proportion was not.

Not all pre-sentence reports were of good enough quality and a small number did not include relevant safeguarding information, leaving sentencers ill-informed. Sentence planning and reviewing progress also needed to improve. The delivery of work to reduce reoffending was not always focused on the relevant factors.

The CRC and NPS working together

The NPS found obtaining information from the CRC about their service users in court difficult because of a mismatch between the two organisations' operating models. The NPS grouped cases by geographical location, whereas the CRC allocated work according to the category of service user (older male, young adult male etc.), making it difficult for the NPS to identify the relevant CRC office for supervision.

The delay in implementing the London CRC 'rate card' had caused difficulties for the NPS in obtaining some services.

Abiding by the sentence

CRC effectiveness

Overall, performance was poor. Fewer than half of the service users in our inspection sample had complied with their sentence.

Delivery of the legal requirements of the court orders and licences, procedures relating to non-compliance and the number of appointments offered were all unsatisfactory.

NPS effectiveness

NPS performance was generally good, with work to encourage engagement and to enforce non-compliance carried out well. Individual diversity was largely taken into account and most service users were meaningfully involved in planning.

The CRC and NPS working together

Working relationships were strained. So for example, CRC breach action requires the preparation of information by the CRC for presentation by the NPS, and there were tensions when NPS enforcement officers considered the information provided inadequate, or CRC staff considered a rejection pedantic, unhelpful or unnecessary. The organisations were working together to try and resolve issues.

Recommendations

The Community Rehabilitation Company and National Probation Service should:

1. produce easily accessible information to enable all staff to make swift contact with relevant colleagues in each organisation
2. require all staff to work together to solve individual problems and focus on the desired outcome.

The Community Rehabilitation Company should:

3. make sure that all functional departments prioritise the operational delivery to service users
4. obtain and regularly scrutinise relevant management information to support effective operational delivery
5. make every effort to reduce caseloads to manageable levels, setting clear priorities for casework activities
6. manage the impact of sickness absence effectively
7. provide all staff with supervision and support in accordance with experience and workload
8. procure sufficient resource within the supply chain to deliver consistent services to all service users
9. provide the rate card to the NPS without further delay.

The National Probation Service should:

10. make sure that all work is sufficiently focused on public protection
11. improve the quality of information at allocation from the NPS court staff to the CRC.

2. The arrangements for delivering probation services in the north of London

- the national context
- the local context
- organisational arrangements

National context

In 2014 the UK government extended probation supervision for the first time to offenders released from prison sentences of under 12 months (over 40,000 people each year[7]). Now, over 250,000 adults are supervised by probation services annually, and all offenders released from prison on licence are subject to supervision. In addition, since May 2015, in an initiative known as 'Through the Gate', probation services must provide offenders with resettlement services while they are in prison, in anticipation of their release.

Probation services were formerly provided by 35 self-governing Probation Trusts working under the direction of the National Offender Management Service (NOMS). They are now provided in a mixed economy model, with an expectation of greater involvement of the third sector. Government wished to promote innovation in probation services, and in June 2014, under the *Transforming Rehabilitation* programme, probation services in England and Wales were divided into a new public sector National Probation Service (NPS) and 21 new privately-owned Community Rehabilitation Companies (CRCs) providing services under seven-year contracts with a lifetime value of approximately £3.7 billion.

The NPS advises courts on sentencing all offenders, and manages those offenders presenting high or very high risks of serious harm, or who are managed under Multi-Agency Public Protection Arrangements (MAPPA). CRCs supervise most other offenders presenting low and medium risk of harm. Probation staff assess and manage the risks offenders pose to the community, to protect the public. They help rehabilitate them by addressing problems such as drug and alcohol misuse, lack of employment or housing, so as to reduce the prospect of reoffending. They monitor whether they are complying with court requirements, so as to make sure individuals abide by their sentence, and report them to court or request recall to prison if they are not.

CRCs operated as companies in public ownership until 01 February 2015 when ownership was transferred to eight separate organisations. Most CRC income is from a 'fee for service' related to the number of offenders under various forms of supervision and the requirements to which they are subject. These payments may be reduced if the CRC fails to meet certain service levels. In addition, there is the possibility of additional income - payment by results - triggered by reductions in reconviction, once relevant reconviction data is available.

The transition from Probation Trusts to the mixed economy model has been challenging (as reported in our series of *Transforming Rehabilitation reports*), and the new expectations of probation providers are demanding. Those serving short sentences are more often prolific offenders, less receptive to rehabilitation. Through the Gate services require persistence and good joint working, and for the moment those arrangements appear the least well-developed.

Nationally, the NPS has higher than predicted caseloads, whereas CRC caseloads (and income) do not match the assumptions underpinning CRC contracts. The

7 Figures relate to releases from determinate sentences of less than 12 months during 2015 (excluding 15-17 year olds). Source: Offender Management Statistics, Ministry of Justice, October 2016.

shortfalls vary across the CRCs. The new arrangements provide opportunities to innovate and develop new systems, but caseload shortfalls have led to financial constraints and uncertainty for CRCs, and a reluctance to commit to longer-term investment or settled arrangements with other providers, including those from the third sector. The government is currently reviewing CRC performance measures and detailed funding arrangements in a Probation Services Review.

Local context

Here we report on probation services delivered by the NPS and the CRC in the north of London, in 8 of the 32 London boroughs: Barnet, Brent, Camden, Enfield, Haringey, Islington, Redbridge and Waltham Forest. The arrangements in London are unusual, in that alongside the boroughs, the Mayor's Office for Policing and Crime is responsible for setting policing and crime priorities for London.

We provide demographic data and information about the area in Appendix 2. The population of London was estimated at 8.5 million people in 2014, while that of the boroughs we inspected was an estimated 2.3 million. Borough populations ranged from 221,000 to 375,000 – in effect, each about the size of a provincial city. The population in all the boroughs inspected is much more diverse than in England as a whole, and Brent is notably the most diverse, with just over 80% of the population from black and minority ethnic backgrounds. We do not have unemployment statistics for the individual boroughs inspected, but unemployment in both inner and outer London is slightly above the national average.

General deprivation is generally higher than the national average, but Barnet and Redbridge differ from other boroughs in that they have notably lower levels of general deprivation, but common levels of crime when compared to the other boroughs.

Reoffending rates across the eight boroughs vary but are not far from the national average. Barnet, Enfield, Redbridge and Waltham Forest are up to 3% below the national average (26%); the rest are up to 4% above. There are fewer previous offences on average for the London offender cohort than for England & Wales as a whole, although this varies considerably by borough.

London is a stand-alone NPS division, one of the seven NPS divisions across England and Wales, and so the city is served by two entities whose boundaries match: NPS London division, and the London CRC.

The CRC is owned by MTCnovo, a company created specifically for the purpose of CRC ownership. The company comprises an American parent company (Management and Training Corporation) and a new UK-based company (novo). In America, MTC manages private prisons and provides services to help people learn new academic, technical and social skills.

The London CRC is the largest in the country by contract value[8], but work volumes (and therefore income) are 12% lower than anticipated. Leaders told us that reduced funding had affected progress and service delivery. MTCnovo also owns a neighbouring CRC, Thames Valley, where work volumes are also lower than anticipated, again by 12%.

8 Target Operating Model: Rehabilitation Programme, Ministry of Justice, September 2013.

London CRC is subject to contract monitoring in common with others. The last publicly available data (April to June 2016) shows that there were 3 categories of service level measure where there were concerns about the integrity of the underlying data, yet to be resolved. Leaving these three measures aside, the CRC was performing above the national average on only 3 of the 16 remaining measures and worse than average on all others. This is noticeably poorer than almost all the other CRCs.

The NPS is also subject to performance monitoring against 25 service levels. Some of these levels do not yet have accurate data or are being revised. Of the 14 measures for which there is data, London NPS was below target on 11 and above target on 3. As such, it is the worst performing NPS division on 5 of the 14 measures; second worst on 3; and third worst on a further 3[9].

Organisational arrangements

The CRC

The CRC was in the process of implementing a change programme, *Ambition 2020*, which was being led by the Director of Transformation who described the current stage, stage two, as qualitative transformation. The programme had 15 themes and 70 projects and the ultimate stated aim was to be the best in reducing reoffending.

Governance

MTCnovo's strategic management team is responsible for finance, human resources, IT, performance and the development of programmes and interventions across the two CRCs in its ownership. A London CRC operational senior management team sits below, with the CRC's Director of Probation a member of both teams. Pending a restructure, the operational senior team comprises a Director of Probation, a (temporary) Director of Transformation, a Deputy Director of Operations and a Chief of Staff. The Deputy Director of Operations and Chief of Staff have previous experience of managing rehabilitation services in the community. These teams are supplemented by a Business Improvement Team which reports to the Director of Probation.

It was recognised by MTCnovo leaders that, given these complex arrangements, there was a lack of clarity about who was in charge and a management restructure was needed. Plans were in train to move resource from MTCnovo's corporate centre into London CRC's senior team. The following two charts show the management structures in place at the time of the inspection and subsequently; further change is planned for the New Year.

9 Community Performance Quarterly Management Information release, Ministry of Justice April–June 2016.

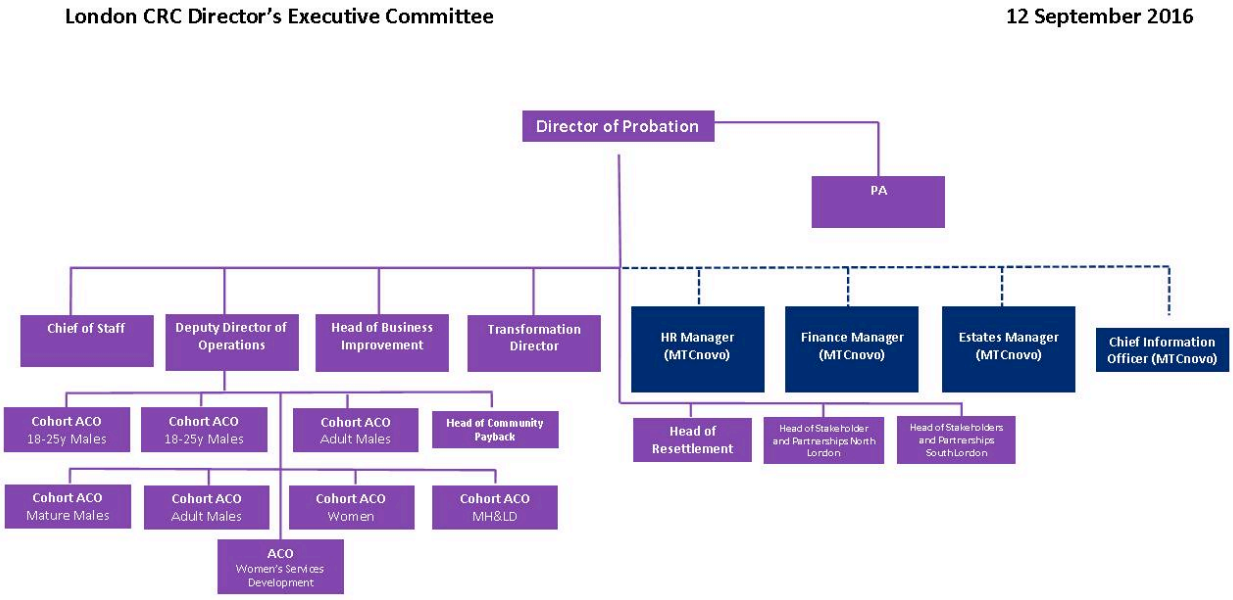


Figure. 1.1. Organogram of the Structure of the London CRC Executive Committee at the time of inspection. Source: London CRC.

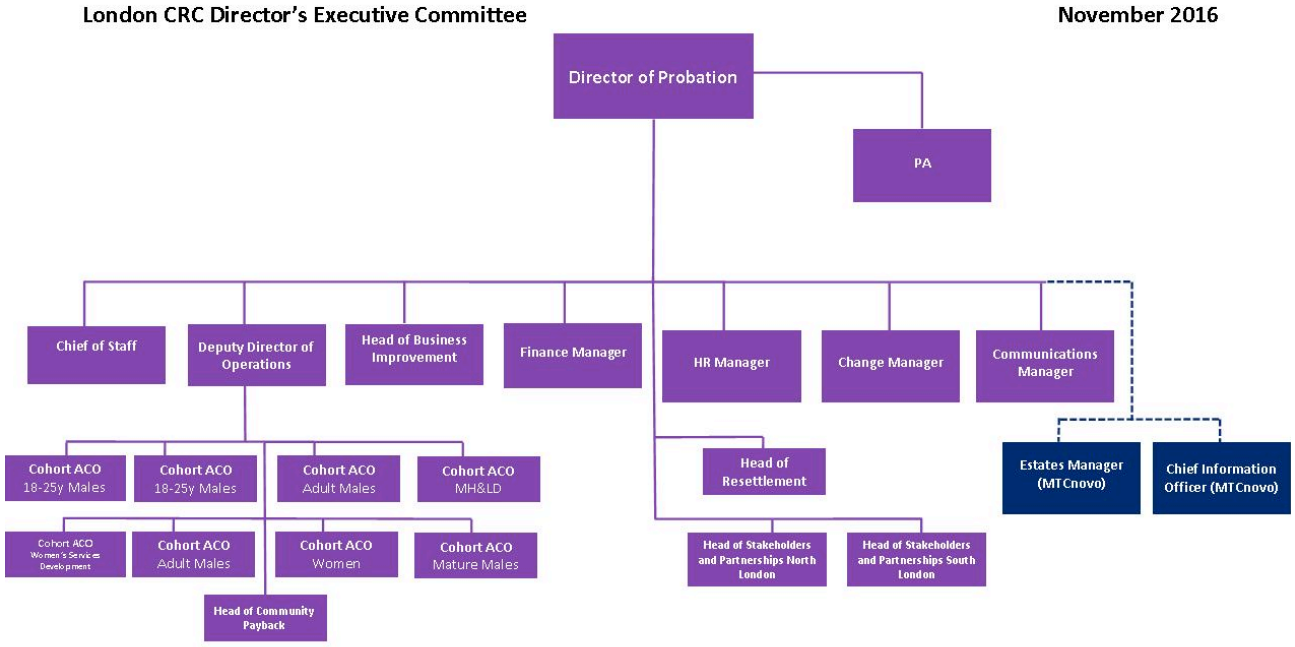


Figure 1.2. Organogram of the Structure of the London CRC Executive Committee post inspection. Source: London CRC.

The operating model in practice

The MTCnovo operating model is unusual[10], in that it groups service users into groups known as cohorts. The cohort model was introduced to promote desistance, develop strong evidence-based interventions, improve opportunities for service users, enable practitioners to specialise, and to maximise the benefits of partnership working to reduce reoffending. It was also envisaged that it would allow for significant expertise to develop within each cohort, helping to continue to improve services and to work with partners to reduce reoffending rates across London. Assistant Chief Officers lead each cohort group, supported by a number of teams.

Cohort model (at time of inspection)
18–25 year old males
26–49 year old males
Women
50+ year old males
Mental health and intellectual disabilities (as the primary presenting need)

Table 1.2 A list of the cohorts being used by the London CRC at the time of inspection. Source information: London CRC.

London CRC introduced the cohort model in December 2015. In practice it has proved difficult: not all cohorts are represented with staff at each office, and the NPS has found it hard to identify the relevant office for some offenders. Those categorised as young adult males and adult males constitute over half the workload, and report to the office in which their responsible officer works, but those responsible officers working with the other, smaller cohorts cover several offices, and so service users attending without appointments are not always able to be seen by their responsible officers. Travelling between offices reduces responsible officers' work capacity. These problems should ease to some extent with the proposed new cohort categories, and as responsible officers for each new cohort in each office are planned.

Cohort models generally constrain the ability to reallocate cases when necessary, for instance because of any change to the cohort model, or when a responsible officer is absent for a lengthy period, and we found that here: staff sickness meant that some service users were not seen for considerable amounts of time. What is more, as the CRC systems do not arrange or monitor future appointments, the CRC had unknowingly lost track of some service users altogether. This is clearly unacceptable. We understand that the cohort model is subject to further review.

An Operations Centre (known as 'the hub') receives cases from court, and checks and chases information before allocating to the relevant cohort. This was designed to cut down the need for administrative support within local offices, and progress was being made in the allocation of cases.

Some administrative tasks (including those relating to appointments, warning letters, enforcement, administrative entries on the case management system (nDelius) and the creation of offender assessment records (OASys)) had passed to responsible

10 MCTnovo apply a cohort model in its neighbouring CRC (Thames Valley), albeit the cohorts are different.

officers. This had increased their workload substantially, and not all had received relevant training. There were plans to review the work of the hub, with a view to moving some administrative work from responsible officers.

Leadership and management

Senior managers considered that the organisation was in a more perilous state than first thought, and that current problems were in effect legacy problems. It was acknowledged, however, that the way in which new IT had been implemented and the rapid move to the cohort model had had adverse effects. Senior managers told us that transformation was likely to take more time than had been originally planned. Staff at all levels were working hard to deliver transformation.

It was clear that operational service delivery was not the priority of all senior strategic managers, with some isolated from the *ultimate purpose* of the business. The impact on service delivery of staffing shortfalls and IT service delays was either not understood or not given sufficient weight. Leaders failed to fully utilise the knowledge and experience of senior staff experienced in probation delivery, which contributed to the failure to prioritise public protection and the quality of service delivery. Rather, they were focused on more immediate contractual (service level) targets.

Management information centred on service level targets. Some management reports available before the implementation of new IT systems had been lost - in particular, details of service users who were not being seen. We were told that this report had been requested by the business improvement team but had not been forthcoming and was not pursued by senior managers, leaving them unaware of the extent of a pressing problem. This was rectified during the inspection and new reports were made available to managers.

Workloads

The CRC senior probation officers (SPOs) have an important oversight role, and now carry additional management responsibilities, including building security, personnel and health and safety management. They had inconsistent workloads: some were overseeing over 900 cases, a proportion of which were assigned to responsible officers on long-term sick leave, and some were managing staff and caseloads in different geographical locations. These responsibilities and arrangements inevitably affected their availability to manage effectively. Formal supervision had reduced and some staff had not received supervision for months.

In allocating cases to responsible officers, little account was taken of the level of experience, ability or training.

We were told by senior managers that MTCnovo had inherited an 'officer to case' ratio of 1:46, that the contract bid had envisaged a ratio of 1:56 and that they were now aiming for 1:55. In practice, individual (and team) caseloads were again inconsistent and varied over time. They generally ranged from approximately 50 to over 100 cases per person. Since the inspection we learned that efforts had been made to reduce individual caseloads, as illustrated by the following two charts from the male adult cohorts:

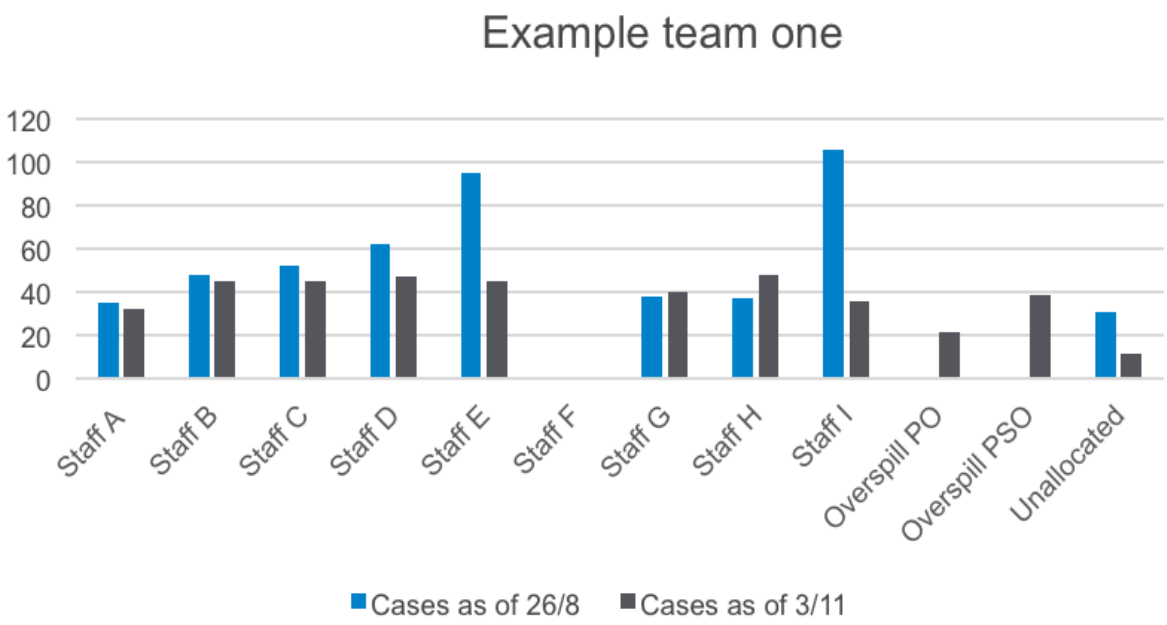


Figure 1.3. Breakdown of caseload per responsible officer for a team in the London CRC pre and post inspection. Source information: London CRC.

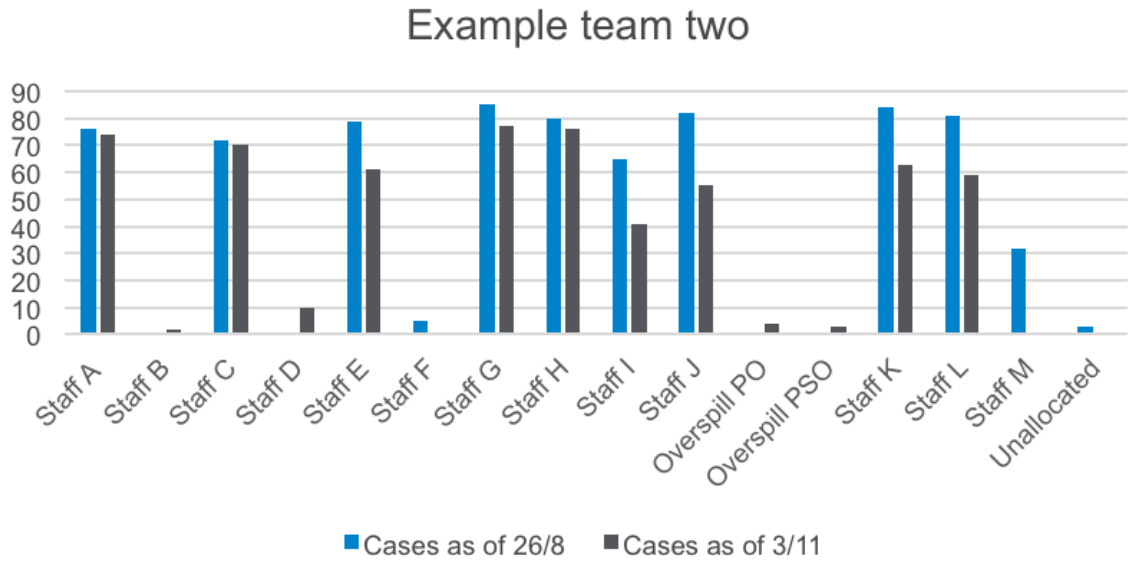


Figure 1.4. Breakdown of caseload per responsible officer for a team in the London CRC pre and post inspection. Source information: London CRC.

This was welcome as, in our view, at the time of the inspection too many responsible officers and SPOs were faced with unmanageable workloads and entirely unrealistic expectations of what could be achieved.

Staffing

Senior managers estimated that they were carrying a 25% vacancy rate at inception, although we were advised by MTCnovo that it was 33%. Either way, they were heavily reliant on agency staff, with associated costs and staff churn. We recognise that staffing in London has long been problematic, with the range of alternative employment on offer in the capital increasing the rate of staff turnover. Within the

CRC, front-line staff numbers had been reduced across London by 15%, broadly in line with the 12% shortfall in work volumes, but nevertheless at the time of the inspection the vacancy rate was still problematic, at 20%. Plans to recruit permanent staff were on hold pending clarity on where staff would be needed as the proposed cohort model changes are implemented.

The level of experience and training varied considerably, particularly within the first grade of professional staff – probation service officers (PSOs). Several PSOs had an administrative background and limited relevant experience, but they were carrying large caseloads. Many had not received formal supervision for many months.

Leaders acknowledged that staff morale was low. Sickness absence had risen inexorably since early 2016. Over the period May to August 2016, the numbers off sick for longer than three weeks had trebled, from 23 to 70 individuals. A Managing Attendance Committee (launched in conjunction with the CRC's occupational health provider) had been set up but, at the time of the inspection, this had had little impact. In the absence of a clear deployment strategy to ease matters, sickness absence continued to have an adverse impact on staff and on delivery. Consequently, two officers in one office were covering the caseloads of five other staff on a duty basis alongside their own regular workload, and there had been six managers of one of the women's cohort teams within a matter of weeks. Workforce planning was reactive at best.

Given the clear staffing shortfalls, we would have expected management to specify clearly the services to be delivered as a priority, but we saw no evidence that this was made clear to professional staff managing excessive and/or changing caseloads. The CRC, however, had plans to improve performance and quality over time. Quality standards known as *Building for Best* had been issued to responsible officers in June 2016. There were also plans to roll out basic offender management training in November 2016, intended to equip all responsible officers with the skills to assess, enforce and engage with service users.

By the end of the inspection, a programme of monthly case reviews by SPOs had commenced, a welcome development.

There was no absence of effort at the operational level. Responsible officers and SPOs were trying hard to deliver services to an acceptable level. We encountered a number who were working long hours regularly, to try to keep up to date.

Office bases

With the exception of a small number of locations, CRC offices are co-located with the NPS in former Probation Trust premises. The number of offices used by the CRC has been reduced from 40 to 27, and senior managers were not convinced that the available estate supported delivery of the cohort model. There were stated intentions to review the situation.

Supporting systems

Delays in implementing new case management systems due to Ministry of Justice (MoJ) dependencies have been found elsewhere on inspection. London CRC had been affected in the same way as other CRCs and leaders were frustrated. We were told that the CRC itself was ready to implement its new systems.

MTCnovo has nevertheless invested in and provided staff with new, mobile hardware with access to the usual office software and legacy case systems. Implementation has been problematic, however, with a substantial impact on workload for responsible officers and SPOs. The change from desktops to laptops was challenging for some staff, exacerbated by poor implementation sequencing, limited ongoing IT support and less than full connectivity.

Training to use the new systems was provided too early, some four months prior to implementation. New staff were allocated laptops promptly, but IT support to allow them to access the network was often delayed. We were told by staff that it could take two days to resolve routine problems through the IT helpdesk, leaving people unable to work. The helpdesk was not available outside the core day, despite operational business extending considerably beyond this. Users of assisted technology had suffered a deterioration in support and continued to experience difficulties.

Although all offices had a means of connecting to the network, in practice the ease of access varied enormously. Staff working in what were described as 'stranded' offices had to rely on insecure wireless (wifi) devices, which were often unreliable and slow. Staff complained that they could not print documents readily, but had to connect their laptops directly to a printer. Without desktop printers they resorted to saving up letters, breach papers etc. before attending the printer (wherever it may be) and waiting for bulk print.

It was clear that day-to-day, operational delivery was not the priority of the IT department, and the impact of the IT difficulties on service delivery had not been sufficiently understood or recognised by the MTCnovo senior management team.

Involvement of the third sector

Inevitably, some boroughs had significantly better local community services than others. For example, a specialist housing worker from the local housing department came into the Ilford office weekly. Although all CRCs work across more than one locality, this is particularly complex in London, given the number and the diversity of boroughs. Substance misuse services, for instance, were accessed through local community provision, and were different in every borough.

The CRC worked with a range of voluntary, community and social enterprises. Accommodation services were provided by St Mungos; post-sentence supervision for adult males was delivered by Penrose; SOVA offered mentoring for men; and St Andrews was the mental health partner. Accredited programmes and senior attendance centres were provided through RISE, a public service mutual.

With the exception of the delivery of accredited programmes by RISE, these services were not being accessed consistently. The supply chain was fragmented and not fully developed. For example, Penrose had anticipated 4,000 cases a year, but were currently working with only approximately 1,000 service users. The requirement to provide an up to date assessment before allocating to Penrose delayed the transfer of cases.

Given the recent recommendations in our thematic inspection of services for women who offend, we were pleased to see that an Assistant Chief Officer had responsibility for developing services for women, including establishing safe spaces in the community from which to deliver services for women. There was no budget for this, however, so it was a slow process. At the time of the inspection, there were no specific, safe places for women in the area that we were inspecting.

The Mayor's Office for Policing and Crime was involved with the CRC in a number of joint initiatives including the Gangs Exit programme for young males and the women's charity, Advance Minerva which had recently been commissioned to provide additional Through the Gate services for women. There were also some posts linked to Integrated Offender Management (IOM) that were funded by the Mayor's Office.

Resettlement services

Help with accommodation was provided through the charity St Mungos, although during the custodial period of relevant sentences this constituted advice only.

There were three main providers of Through the Gate services: Penrose, Catch 22 and Novus. In theory, these agencies delivered an 'end-to-end' service; in practice, we saw little evidence in the inspected cases of the delivery or impact of these services.

Through the Gate services to women were delivered by CRC resettlement facilitators in the women's prisons HMP Downview, HMP Send and HMP Bronzefield. There was an assessment screening prior to release and a resettlement plan was produced. We were told by senior managers that homelessness remained an issue however, and both men and women were released with nowhere to live. There was no data available to establish the extent of this problem. A service (recently commissioned from Advance Minerva) to meet women at the prison gate and support them with their resettlement plan had yet to start.

The NPS

The NPS is a relatively new national, regionalised organisation. Operational services are generally delivered in-house save for those commissioned from the CRC. Staff are drawn predominantly from the former Probation Trusts. The NPS is midway through an ambitious programme (known as E3) to standardise processes nationally.

Leadership and management

Senior managers described a period of restructure and reorganisation both internally and in the wider world of partnerships and stakeholders. This had taken considerable time and effort and it was acknowledged that the quality of operational service delivery had not had the senior management focus required. Notwithstanding this,

local leaders considered the organisation was now more stable, that plans were in place and that quality assurance processes had been established to extend and embed good practice.

Court work was recognised as a significant and long-standing challenge. Considerable effort had been made to improve services but it was acknowledged that there was still much work to be done. There was a conflict between the pressure from courts to provide same-day reports and the need to obtain information and provide good enough risk assessments to responsible officers in both the NPS and CRC. In reality, both were not always possible and inevitably risk assessment was sometimes falling into the post-sentence phase, meaning that the supervision of some service users commenced before the risks that they posed were known. This potentially left some victims at risk.

Staffing and caseloads

Overall, staff morale was good. There was a sense of stability. Most of the responsible officers with whom we spoke felt that there was a focus on the quality of work and that they were enabled to deliver that through the support of managers and colleagues.

At inception, the NPS had not retained any PSOs, however under E3, recruitment of PSOs was now underway and the organisation had also invested in training new probation officers (POs). There continued to be what was described as a 'traditional workforce churn'. Like the CRC, the NPS had inherited a high sickness rate and although short-term sickness absence was beginning to subside, longer-term absence remained a difficulty and had a particular impact on the smaller offices. Managers considered that the new processes inherent in the move to shared corporate services had not been helpful in this respect.

Prior to *Transforming Rehabilitation*, specialist supervision had been available to staff in addition to that provided by line managers, but was no longer. Senior managers were aware of the stress that high risk caseloads might cause in such circumstances. There was the potential for this to be exacerbated when PSOs eventually took the less complex cases. They were keen to support staff and first line managers, and some workshops, Building Resilience and Staying Safe, had already been delivered.

NPS caseloads were lower than those of their CRC counterparts. Clearly, this reflects the nature of the caseload. Full-time practitioners in one local delivery unit (LDU) cluster, for example, held caseloads ranging from 33 to 58. There were some inconsistencies in caseloads, although most responsible officers told us that these were manageable. It was acknowledged by senior managers, however, that these inconsistencies needed to be resolved. Newly qualified probation officers received a protected, lower caseload for nine months.

Office bases

The estate strategy was described as work in progress. It had become clear that original MoJ plans would not meet the needs of the organisation's service users. The previous estate of London Probation Trust had been retained and funding secured

to obtain newer offices in the most pressing areas, to retain local links and enable service user engagement. The imperative was to ensure an operational presence in as many London boroughs as possible, and, in collaboration with wider partners, such as the police, build a resilient long-term estate.

The NPS paid the CRC for services such as reception, and work had been done to clarify local property agreements.

Supporting systems

As a new organisation, the NPS had spent time establishing structures or rearranging inherited arrangements. Data and information available prior to *Transforming Rehabilitation* had been lost, and that now available to the NPS through NOMS was less comprehensive. Initially it had only been possible to obtain pan-London data. LDU Cluster level data was now available but nothing more detailed or local. The London team had worked with NOMS and the national NPS team to further develop the management information produced.

Moving to shared corporate services had been testing and operational difficulties remained. In particular, occupational health, procurement and recruitment systems were problematic, with dealings described as 'a battle'.

IT was described as endlessly frustrating and an embarrassment, with access to assistive technology a real problem. When the MoJ IT contract was unable to deliver, the NPS had spent six months trying to find old computers and recondition them to use in courts. These problems had yet to be resolved. We have encountered such problems in other locations during our recent inspections.

The implementation of the CRC rate card had been delayed and had caused difficulties. It was not available to the NPS at the time of the inspection, which was neither acceptable nor typical of what we have found elsewhere. The cost for some services had originally been much higher than was paid to the legacy contracted providers. Without a rate card the NPS had not purchased any of the discretionary services as yet. Some legacy contracts had been retained, such as mental health and housing services, and attempts were being made to persuade the MoJ to procure longer-term contracts for these services. Employment and skills services were proving difficult to find for a large group of offenders; some boroughs had no provision.

3. An evaluation of the quality of probation services in the north of London

- Protecting the public
- Reducing reoffending
- Abiding by the sentence

Protecting the public

CRC effectiveness

Overall CRC performance was poor. The proportion of work carried out to a sufficient standard was low, leaving the public at undue risk.

Unmanageable caseloads resulted in too many responsible officers being reactive and concentrating on the service users who reported, rather than prioritising those who posed the most risk of harm to others. More than one described their approach as 'fire-fighting'.

The lack of a credible system to monitor the cases when responsible officers were off sick had meant that too many service users had not been seen for weeks or months and, in some cases, had been lost in the system entirely.

The CRC policy was that, where local management deemed it appropriate, PSOs could carry cases with domestic abuse or child safeguarding issues. These factors were not always recognised in assessments, however. It was, therefore, not clear that managers were actively making the decisions to allocate these cases to PSOs.

A lack of formal supervision did not allow SPOs to properly monitor inexperienced officers' understanding and awareness of risk factors. Many of these factors had previously been identified by Serious Further Offence reviews in the London area.

Assessment and planning

The assessment of the risk of harm posed to others, and subsequent planning was not carried out well enough in over half of the cases inspected. Assessments were not up to date and had missing or incorrect information. Significant information was not always recognised as such and there was a lack of awareness of domestic abuse and child safeguarding issues. This problem was exacerbated where screenings or assessments from court did not include all relevant information.

The failure to identify properly the risk of harm posed to others at the start of the sentence or licence meant that responsible officers could not prioritise protection of the public or potential victims. The following example[11] typifies this:

11 Please note, all names in the practice examples have been amended to protect the individual's identity.

Poor practice example: *Peter was 40 years old and had a long history of offending.*

At the time of the inspection in September 2016, there had been no risk assessment since September 2014 when a risk screening had failed to identify previous convictions for possession of weapons and he was assessed as posing a low risk of serious harm to others. He had since received one community sentence and three custodial sentences without a risk assessment being completed.

While on licence, in June 2016, an allegation of domestic abuse was made by a woman with whom he was living, and he was recalled to prison.

He had since been re-released at the end of his sentence and was now subject to post-sentence supervision. There was no assessment in place of the risk of future domestic abuse and no flag on the database identifying him as a domestic abuse perpetrator. It was not clear where he was currently living and whether or not he was living with a partner. In these circumstances, we had no confidence that potential victims were protected from this offender.

Other cases demonstrated a more thorough and engaging approach, as in this example:

Good practice example: *David was sentenced to a 12 month suspended sentence order for drug-related offences and racially aggravated harassment. He had been supervised by probation services previously as he had a pattern of substance misuse. He had problems controlling his anger and so had been difficult to work with at times. He also had long-term accommodation problems and a history of depression.*

The responsible officer was his third officer and he was resistant to engaging. Her assessment recognised the significance of this and the impact of his unstable accommodation on his behaviour. She demonstrated clear resilience and persistence in working with him, and her approach, taking into account the disruption caused by the number of officers, was clearly documented.

Her efforts helped him to engage not only with her, but also with his accommodation key worker and he was more able to discuss issues in appointments rather than his historic approach of arguing and challenging.

Delivery

There was a lack of recognition and response to public protection concerns. The work was not focused on protecting those at risk of harm from the service user in over two-thirds of the cases in our sample, and all reasonable action had been taken to minimise the service user's risk of harm to others in less than half of cases.

Reviewing progress

The responsible officer reviewed progress sufficiently against the public protection priorities in only 5 of 31 relevant cases and responded appropriately to changing circumstances in only 7 of 23 relevant cases. Again, it was not clear that risk factors were always recognised. Reviews had not taken place at all in some cases, notably where services users were not being seen, as in the following case:

> ***Poor practice example:*** *Tarish had assaulted his wife when their two year old child was in the house. As part of his bail conditions, he was not allowed to have contact with his wife. Children's social care services had made an assessment of the safety of the child and, based on Tarish's absence from the family home, they had discontinued their involvement. On sentencing, he returned home but there was no record that children's social care services had been advised of that.*
>
> *Tarish initially attended appointments, however, by the time of the inspection, he had not been seen for five months. In April 2016, he had been instructed to attend an appointment the following month. When he did not attend, this was not picked up for enforcement or for further appointments to be offered.*

Impact and potential impact

The responsible officer had made sufficient progress in influencing the risk of harm posed by the service user in just over one-third of inspected cases.

The following table identifies the key enablers and barriers to the work of the CRC contributing to public protection:

Enablers		Barriers	
1.	Where individual officers and managers were experienced, they demonstrated knowledge and skill in managing risks of harm posed by service users. Staff made sterling efforts to deliver a service to offenders, despite the challenges they faced.	1.	Unmanageable caseloads led to lack of contact with service users. The absence of credible arrangements to cover for sick absence, together with limited operational and senior management oversight, compounded this problem.
		2.	Complex cases were often assigned to inexperienced officers, some of whom demonstrated a lack of awareness and understanding of risk factors.
		3.	Workload pressures meant that staff struggled to keep on top of public protection work, in particular, failing to maintain up to date risk assessments. A lack of effective monitoring of caseloads and service user attendance exacerbated this problem.

NPS effectiveness

NPS performance was mixed. Overall, most of the public protection work was carried out sufficiently well, but the proportion of cases where the standard was not good enough was too high. Given the risk profile of the NPS caseload, attention needed to be more sharply focused on public protection work. A team of quality development officers was being established, to be located in the LDU clusters with the remit of improving the quality of practice. This was a promising initiative.

The NPS in London had established a serious case advisory unit in December 2015, as a response to the threat of serious crime. The unit focused on gangs, organised crime and extremism and had regular access to police intelligence. Staff working in the unit provided advice and support to the front-line responsible officers who managed the cases, co-working those identified as Terrorism Act cases. Although we saw only one case managed under this process, we were nonetheless impressed by what we saw and heard about the work of this unit.

Allocating cases

We saw a small number of cases, assessed as high risk of serious harm which, in our view, did not merit that level and should not have been allocated to the NPS. The following case exemplifies this:

> ***Poor practice example:*** *Misram was sentenced to a community sentence for two common assaults on his partner when he was under the influence of alcohol. There were no children involved and he had no previous convictions or other aggravating factors. The pre-sentence report (PSR) was clear and sufficient but in our judgement the report author had assessed the risk of harm level as too high. This led to allocation to the NPS when the case should have been with the CRC.*

The quality of the case allocation forms and/or risk assessments prepared at court by the NPS was mixed at best. Too many contained 'don't know' answers. Sometimes this was the case even where there was clear evidence available about domestic abuse and risks to children. This raised concerns for us about the accuracy of the information supplied to sentencers; another consequence was that responsible officers and SPOs were not always aware of risk issues until some time after the cases had been assigned. These problems were known about and understood, although managers felt that expectations for court work were too high. The NPS Court Delivery Project in the London division was working to improve performance and embed effective quality assurance into court processes.

Assessment and planning

The assessment of the risk of harm posed by the service user was carried out to a sufficient standard in three-quarters of the cases inspected. The proportion in which planning to manage risk was carried out well enough was a little lower, at two-thirds of cases. Too many risk management plans did not contain clear actions to protect victims or potential victims. Quality assurance had recently been implemented for this area of work.

Delivery

The work delivered by the responsible officer was not sufficiently focused on protecting those at risk of harm from the service user in 7 out of 20 relevant cases. In those cases, there was often work to reduce reoffending but not enough attention was paid to protecting the victim or the public. In a similar number of cases, we judged that not all reasonable action had been taken to minimise the risk of harm posed. Practice varied, however, as the following two examples demonstrate:

Poor practice example: *Paul received a 24 month suspended sentence order for breaching a restraining order, imposed to protect his ex-partner. The order included a curfew and an exclusion zone. Paul was initially hostile about engaging with probation, but his responsible officer eventually built up a positive relationship with him. The responsible officer focused on how to change Paul's attitude, thinking and behaviour but paid too little attention to managing the risk of harm he posed. The plan to manage risk of harm did not consider, for example, how the exclusion zone, curfew or restraining order would work to protect victims. There was no consideration of how to protect potential future victims (his current partner) or how safe contact with his children would be facilitated. In our view, the work was insufficiently focused on managing the risks posed.*

Good practice example: *Shane was already subject to a community order and a criminal behaviour order when he was sentenced to custody for a violent offence. He had an extensive offending history and was linked to gangs. During post-sentence supervision, the responsible officer communicated effectively with other professionals, so as to make sure that Shane's risk was managed appropriately. On one occasion, the responsible officer showed courage in giving Shane a formal warning after he had behaved in an intimidating manner. Later, he recalled him to prison after he failed a number of drug tests while at an approved hostel. This gave Shane a clear message and engagement improved significantly thereafter. There had been no convictions for some nine months post-release.*

MAPPA had contributed to keeping people safe in five out of six relevant cases. We saw a number of cases with IOM involvement, some where MAPPA was also involved. In these cases, it was not always clear what part IOM was playing. Arrangements were different in different offices. In Haringey, for example, there was a designated responsible officer who managed all the IOM cases, whereas in Walthamstow, IOM cases were supervised by any of the responsible officers. The following exemplifies where IOM failed to fully support MAPPA:

Poor practice example: *Martin had received a four month custodial sentence for assault. He had a history of violence against partners and was alcohol dependent. The case was being managed through IOM and MAPPA. MAPPA had made a significant difference to the management of the risk of harm that Martin posed.*

The responsible officer prioritised well, recognising the need to find Martin his own accommodation so that he did not continue to gravitate to the homes of ex-partners. There was too little planning, however, around his use of alcohol, the residence requirements, the non-molestation order, and the part IOM could play.

Until MAPPA was put in place, plans were entirely supportive rather than considering the need to control him and to protect victims.

Martin went on to breach his non-molestation order. He went missing and was found to be staying with an ex-partner. Enforcement action was taken but he went on to assault his current partner.

In only 8 of 14 relevant cases, the responsible officer recognised and responded appropriately to changing circumstances. This was done well, however, in the following example:

Good practice example: *Sharon had been the subject of domestic abuse over many years. She received a community order for assaulting her ex-partner who was the father of her child. Although the relationship had ended, there was frequent contact between the two parents. Safeguarding needs were managed well by the responsible officer who made regular contact with the local intelligence unit to check reports of arrests and new incidents. Additionally, the contact with children's social care services was meaningful and directed at keeping the child safe. Following a fresh incident during which Sharon was assaulted by her former partner in front of the child, an immediate referral to a Multi-Agency Risk Assessment Conference was triggered and a case conference called. This brought a range of partners together in order to discuss and agree the actions necessary to keep the child safe.*

Reviewing progress

Progress was reviewed sufficiently against the public protection outcomes in only half of the cases inspected. Some responsible officers were alert to the benefits of regular reviews, as in the following example:

Good practice example: *Percy was convicted of kidnapping and false imprisonment. He had links to gangs and a history of violence, particularly towards his partners. He was recalled to prison soon after release. The responsible officer recognised that time left on Percy's sentence was running out and convened a sentence planning board promptly. She noted that no work had been completed while he was previously on licence so, along with Percy, identified work that could be achieved quickly while he was still in custody. She convened a second sentence planning board three months after the first to identify further work with which Percy could engage.*

Impact and potential impact

The responsible officer had made sufficient progress in influencing the risk of harm posed by the service user in nearly two-thirds of cases. The following example illustrates what could be achieved with well-coordinated effort:

Good practice example: *Phillipa had been convicted after trial for an offence of making preparations for a terrorist offence and was sent to custody. On her release, the case was jointly supervised by the responsible officer and an officer from the serious case advisory unit. Weekly meetings took place throughout the course of the licence. The quality of work delivered was excellent, with one module of work around health and identity being delivered to a high standard. The two workers had spent many sessions trying best to understand the root causes of the offence. The pace of delivery was measured and appropriate. This had resulted in a significant attitudinal change in Phillipa.*

The following table identifies the key enablers and barriers to the work of the NPS contributing to public protection:

Enablers		Barriers	
1.	Caseloads were generally manageable.	1.	Pressures within the court setting hampered full and accurate completion of risk assessment and case allocation system (CAS) forms at the court stage.

2.	Staff were described as "resilient and capable", which was evident in many of the well-managed cases.	2.	In too many cases, there was a lack of clear focus on public protection, and a failure to review and respond to changing circumstances.
		3.	There was a lack of clarity around use of IOM.

The CRC and NPS working together

Most of the staff with whom we spoke described reasonable or good working relationships in the co-located offices, although it was acknowledged that staff were becoming more distant. There were rubbing points around some of the logistical arrangements concerning, for example, reception and health and safety. The different operating models - geographic and cohort - had made communication at all levels between the organisations more difficult.

The CRC reported that the assessments they were receiving from court were diminishing in content and quality. The omission of information from the CAS, and the consequent delay in risk assessment, caused difficulties and potential risk of harm to victims, as well as extra work for CRC responsible officers. The CRC collated information about difficulties encountered in receiving information from the NPS, which was discussed at meetings of a Service Integration Group. Missing paperwork, including the Risk of Serious Recidivism calculation and the CAS, remained the biggest problem.

Risk Escalation

NOMS had expressed some concern, raised via the Service Integration Group meetings, that the CRC were escalating too few cases. The CRC position was that they received a high number of rejections to those cases which they did escalate. The NPS had a central unit to which escalations were initially referred. A joint audit in 2015 showed that some of the cases should not have been rejected. Further joint work was ongoing to address this issue.

We did not see any cases in the inspection that should have been escalated.

The following table identifies the key barrier to the work of the CRC and NPS working effectively together to achieve positive public protection outcomes. There were no identified enablers to this work.

Barriers	
1.	Inadequate risk assessment at court created problems for both organisations, and CRC responsible officers in particular.

Reducing reoffending

CRC effectiveness

CRC performance was poor. In some cases, the levels of contact were concerning and unacceptable. We found some good offending behaviour work but overall there was little evidence of a coherent approach – through assessment, planning and intervention - to the work. One staff member told us that they felt that offender management had got lost amid all the change that had taken place, and so it seemed to us. The CRC had, however, developed practice standards under a framework, *Building for Best*, introduced in May 2016 and there was some evidence in a small number of cases of those standards starting to have an effect.

There had clearly been an impact of the loss of administrative support and IT difficulties. It was evident that some service users had reported, without their attendance being recorded. We were told that this was the result of systems malfunctioning and records not being brought up to date subsequently. This had previously been identified as an issue in Serious Further Offence reviews.

Assessment and planning

Incomplete information in assessments arriving from court made starting work with service users more difficult, and reassessment by the CRC more urgent. Notwithstanding these difficulties, it was concerning that the necessary reassessments had not been carried out within an appropriate timescale in three-quarters of the cases inspected. Senior managers had recognised this was a problem earlier in the year and had issued a directive that all cases should be brought up to date. This had not been successful.

As a consequence, there were sufficient sentence plans in only seven cases out of those inspected. Where plans existed, few addressed the factors associated with potential reoffending. For example, only 2 cases had plans to address drug misuse out of 15 that we identified as needing that type of intervention. Planning to carry out thinking and behaviour work, a major part of the work, had only featured in five cases. The following two examples show the importance of appropriate planning – and what can go awry without it:

Poor practice example: *Charlie was convicted of a burglary and received a custodial sentence. He spent a short time in custody and was released after two months, in December 2015. He went to live with his aunt, with whom he had not lived before. There was no assessment carried out or any sentence planning. He provided little information and he was not challenged about this. Subsequent events showed that he was withholding information. His address was a fake and he had an unknown pregnant partner, who may or may not have been at risk of harm from him.*

Charlie attended the appointments made for him, ten in seven months. He was in the IOM cohort but the first contact with IOM was not until five months after release. There was no work on his offending behaviour.

In August 2016, Charlie was charged and recalled to prison for armed robbery and grievous bodily harm. The circumstances of the offence were very similar to his previous offending, although the use of weapons, an axe and a machete, was an escalation in seriousness.

Good practice example: *The case of Shannon, a woman from the travelling community, was assigned to an officer who had knowledge and an understanding of that community. The responsible officer's initial assessment identified literacy problems and she was, therefore, able to tailor communications appropriately. She had also understood how important family was to Shannon. She had a warm and caring approach and had made significant and successful efforts to engage Shannon. As Shannon was considered to pose a low risk of harm to others, the responsible officer geared interventions towards practical assistance, which Shannon found helpful.*

Delivery

For most cases there was little indication that assessment or planning were driving work with service users. The biggest obstacle to delivering interventions, however, was the lack of contact in too many cases. Often, the level of contact was so poor that it could not be expected to make any difference to the offending of those under supervision.

Poor practice example: *June was known to be dependent on class A drugs. Prior to imprisonment, she had lived with her father. On release, she failed to attend appointments and disappeared into the community. The responsible officer made a home visit and was informed by June's father that she had disappeared and a breach warning letter was sent in January. There was then no further attention to the case until the end of April, when an attempt was made to re-establish contact. June had by then committed further offences including possession of a knife. Breach proceedings were commenced and she was resentenced for the breach and further offending.*

Availability of services across the boroughs was variable; for example, we were told about a women's empowerment group that ran in Romford three times a year. An eight-week programme had just finished and we saw evaluation forms from the last group which were positive. The programme was originally developed in conjunction with the local borough, and was now run by the CRC women's cohort in that locality, with strong links to community groups. The programme included money management and benefit advice, information on healthy relationships and domestic abuse, sexual health and managing emotions. The programme did not operate in any other borough.

In a small number of cases, we judged that responsible officers had contributed to the service user achieving the desired outcome. The contribution of partner agencies was difficult to judge, as communication between agencies was not always clearly recorded. The following case illustrates what could be achieved, through effective partnership working:

Good practice example: *Steven had a long history of alcohol-related offending, covering a wide range of offences. He was made subject to a community sentence with an alcohol treatment requirement. He had fully complied with this requirement and there was excellent communication between the treatment provider and the responsible officer, including three-way meetings with Steven fully involved.*

Integrated Offender Management

It was unclear what contribution IOM was making to the management of service users. We found no discernible difference in the levels of contact, as we might have expected with this prolific group of offenders. Gripping the Offender was a new project providing an enhanced service for the IOM cohort covering Camden, Enfield, Haringey, Islington and Waltham Forest. It was designed to deliver an intensive service. We were unable to judge the impact of this as there were no cases in the inspection sample.

Poor practice example: *Frank was sentenced to four weeks additional custody while already subject to a custodial sentence. He had a long history of drug-related offending including violence and robbery and he had an increasing alcohol problem. His case was sentenced without a PSR, at his request, and no assessment was carried out. Subsequently, on release, there was no assessment of the risk of harm that he posed or any kind of plan.*

No interventions were delivered in this case. From the point of release in December 2015 until September 2016, Frank had been seen on only three occasions. It appeared from the case records that he might have been in custody for some of that time, but that was not clear.

There was no evidence that the responsible officer knew of Frank's whereabouts, whether he was offending or if he had continued to use drugs and alcohol, thereby maintaining the high risk of reoffending. There was no evidence of communication with other agencies despite Frank being an IOM case.

Rehabilitation activity requirement

The rehabilitation activity requirement (RAR) came into effect in February 2015, providing greater flexibility about the precise nature of what could be delivered during a community sentence. Responsible officers gave differing explanations of how RAR days were carried out. Some told us that they were meant to refer to partner agencies and monitor attendance. This was not without difficulty as communication was inconsistent. Some partners, for example women's services, considered themselves voluntary and were not as diligent in reporting failures to report. Other responsible officers told us that they carried out the RAR days themselves, effectively reverting to supervision. The decision on the way that RAR days were delivered appeared to bear little relation to need. In an attempt to raise awareness about RARs, the CRC had issued guidance and briefings for staff. The uncertainty about how to use the RAR to best effect mirrors what we have found elsewhere, including on our recent, as yet unpublished, thematic inspection of this aspect of probation work.

Unpaid work

Overall there were 500 unpaid work projects taking place across London every day. There is a requirement that unpaid work hours are completed within a 12 month period. At the time of the inspection, there were 1,000 cases across London that were approaching the end of the 12 month period and a further 800 which had already expired without being completed. This problem had recently been uncovered by NOMS, but the reason for the delay in completions was not known at the time of the inspection.

From September 2016, the management of unpaid work had been restructured and stand-alone unpaid work cases were to be managed under a specific CRC cohort. The first task for the new team was to understand the reason for the delay in completions and to re-engage service users where necessary.

Meeting the needs of service users

As a result of the lack of assessment, planning and contact, most service users had not received a service that met their needs or was likely to help them to stop offending. The following case demonstrates the importance of focusing on individual needs:

> ***Poor practice example:*** *A basic custody screening identified that Keith had a number of key issues to be addressed, including accommodation, employment, and alcohol misuse. On release from custody he was only on licence for seven days, but did attend further post-sentence supervision contacts until he received a further custodial sentence after four months in the community. Keith remained homeless throughout his licence and supervision.*
>
> *No alcohol support was offered, despite Keith attending his appointments in an extremely intoxicated state. It was believed, but not confirmed, that he had accessed help himself on a voluntary basis.*

Reviewing progress and having an impact

In most cases, responsible officers had not reviewed progress or adjusted planning where necessary. In all but a small number of cases, there was no evidence that the service offered by the CRC had had any impact on reducing the reoffending of service users. We judged that sufficient progress been made in delivering required interventions with only 9 of the 40 CRC service users.

> ***Poor practice example:*** *Ahmed was convicted of drug dealing and sentenced to custody. At the time of sentencing he was on licence for other drug-related offences. There had been no interventions undertaken and limited contacts all of which had taken place on Ahmed's terms. There had been no challenge to his entrenched drug dealing behaviour and he had demonstrated a degree of unacceptable behaviour towards the responsible officer which had not been addressed sufficiently.*
>
> *No progress had been made towards reducing Ahmed's offending behaviour and he was not held to account for poor behaviour towards the responsible officer. There was no evidence that there had been any review of the progress of the order or any adjustment of the planning to try to tackle his behaviour.*

The following table identifies the key enablers and barriers to the work of the CRC to reduce reoffending:

Enablers		Barriers	
1.	The women's empowerment project provided a good service to this particular cohort in the one borough that it operated and was well received by service users there.	1.	Unmanageable caseloads, coupled with administrative burdens and IT difficulties for responsible officers, led to a lack of contact with service users.
2.	There was a high level of commitment and continued effort from staff and managers to provide services, despite all the logistical challenges.	2.	Senior and operational management oversight was limited and had not ensured sufficient operational delivery.
		3.	Information and resources to support the delivery of innovative interventions via RAR days were lacking. Communication with partners was inconsistent.

NPS effectiveness

NPS performance was mixed. The majority of work was of a satisfactory standard but we would have expected a higher proportion to be judged so.

Court reporting

NPS court staff provided stand down and oral reports to the court, as well as short format reports. The service estimated that reports on the day now formed 50% of those produced. There was no formal evaluation of oral reports currently, but an audit tool was being developed for this purpose.

We saw some good reports with thorough assessment and sound proposals. Of the 32 reports we inspected, over three-quarters were judged to be sufficiently analytical and focused on the right issues in the proposal. Four did not include relevant safeguarding information.

Assessment and planning

At the point of allocation, the overall assessment in relation to reducing reoffending was sufficient in just over two-thirds of cases. Within an appropriate time following allocation, the overall assessment in relation to reducing reoffending was sufficient in the same proportion.

Only 11 of the 21 NPS cases had sufficient sentence planning in place within an appropriate timescale. Generally, planning at the start of the order or licence addressed the factors associated with potential reoffending, although emotional issues and mental health were only addressed in four out of eight relevant cases. Planning to support relevant protective factors was in place in only 11 out of 20 relevant cases.

Delivery

In most cases, we judged that the responsible officer had contributed sufficiently to achieving the desired outcomes, although this was less so in relation to attitudes to offending and lifestyle and associates. NPS data showed that these two areas were considered to be linked to reoffending in around 70% of cases.

Poor practice example: *Wayne was sentenced at Crown Court for a violent offence. The assessment contained a good offence analysis which showed the need for offending behaviour work; however, no offending behaviour work had been carried out. He had been seen on only nine occasions in six months. The meetings that had taken place simply updated his personal circumstances, with no reference to offending behaviour work or risk management.*

Good practice example: *Anahita had been given a custodial sentence for a non-violent offence. Her husband had offered to sit in the monthly licence appointments to interpret but the responsible officer recognised the need for Anahita to be seen alone. Until the responsible officer was confident that they could communicate sufficiently well together, she made sure that an interpreter was available for supervision sessions. Additionally, she noted how well the initial interpreter and Anahita related to each other and made sure that the same person was present for each session. This led to improved engagement and an apparent improvement in Anahita's confidence level.*

Reviewing progress

The responsible officer had reviewed progress in 13 out of 18 relevant cases and had adjusted planning accordingly in a similar proportion. The following examples illustrate this being done well, and not so well:

Good practice example: *Colin was given a custodial sentence for burglary. He had been motivated to change prior to his release from custody; however, despite being offered a package of support from his responsible officer, he quickly broke the terms of his licence. He failed drugs tests and did not attend appointments. The responsible officer took an investigative approach to understanding his non-compliance. She adjusted her approach to the work to assist with compliance, for example, changing venues and convening multi-agency appointments. Several agencies were involved including IOM, mental health and drugs services. Despite Colin's non-compliance, none of the partners withdrew their services: all were determined to achieve the best outcomes for Colin and the public.*

The responsible officer constantly reviewed work and progress in the case in line with the ongoing need to protect the public and reduce Colin's prospect of reoffending.

Poor practice example: *Barry had received a custodial sentence for a violent offence. The only assessment was a copy of a previous one which did not reflect the current circumstances or issues in the case. The assessment was not reviewed on release, nor was a plan produced. The licence period was short so the time available to work with Barry was limited; however, the time was not well used.*

The work was not reviewed nor was there any reflection on progress or, rather, lack of it. A 'known adult' was considered to be at risk of harm from Barry but there was nothing to suggest who that was. Information about previous children's social care services involvement in the case had not been followed up.

Impact and likely impact

Up to the point of inspection, sufficient progress had been made in delivering required interventions in 11 out of 20 relevant cases. The following provides a good example of what could be achieved despite adverse circumstances:

Good practice example: *John had received a custodial sentence for a violent offence. The contracted service for Through the Gate services did not help him with accommodation and he was homeless on release. On realising that he was to be homeless, the responsible officer made sure that there was a condition in his licence to attend the local authority homeless person's unit immediately on release. The responsible officer had a good understanding of why and when John offended and had put a basic sentence plan in place to try to prevent this. John had had a brain injury which affected his memory. The responsible officer took into account that John could not remember things.*

Partner agencies in this case included the homeless persons unit and the drugs agency, R3 (previously Redbridge Drug and Alcohol Service). Both provided services to John, R3 continuing to do so after the end of his licence to support abstinence. The homeless persons unit offered help to pay a deposit for accommodation and rent in advance as they were unable to accommodate him themselves.

There had been several positive outcomes in this case because of work undertaken with John. He was no longer misusing drugs, he was in a positive relationship with a partner and was starting to rebuild relationships with his sisters and his children, from whom he had been estranged.

The following table identifies the key enablers and barriers to the work of the NPS to reduce reoffending:

Enablers		**Barriers**	
1.	Effective joint work with partner agencies supported positive outcomes being achieved.	1.	Services offered prior to release (via the Through the Gate contract) – such as in relation to housing – were weak.
2.	Where responsible officers took an investigative approach and kept cases under continuous review, the chances of success were greater.	2.	Where initial assessments were not reviewed, or where planning was lacking, the chances of successful outcomes were hampered.

The CRC and NPS working together

The relationships between the two agencies around court work were strained. The NPS reported that there was a lack of information from the CRC when cases were returned to court for review. We were told by the NPS that courts were raising concerns that the CRC were not delivering court sentences as required. We found no evidence of this, however. In one PSR, we were surprised to read a statement implying that the CRC was not delivering a good quality service. The NPS Court Delivery Project was working jointly with the CRC to address interface issues.

The delay in implementing the rate card meant the NPS had not been able to purchase any services through that mechanism. This had not only impacted on the services available to NPS service users but had also reduced the expected revenue of the CRC. The CRC was expecting to be able to deliver the rate card imminently.

The following table identifies the key enablers and barriers to the work of the CRC and NPS working together to reduce reoffending:

Enablers		Barriers	
1.	Where issues of concern were identified, relevant project work was initiated to try and resolve these.	1.	Lack of information exchange for court purposes hampered safe and effective sentencing.
		2.	The delay in implementing the rate card impacted on what was available for service users and on CRC income.

Abiding by the sentence

CRC effectiveness

The CRC's performance was poor. Again, this hinged on the poor levels of contact with too many service users and the lack of monitoring systems.

Delivery

The number of appointments offered was not sufficient to meet the individual's needs in half of the cases inspected. The legal requirements of orders or licences were not

satisfactorily delivered in nearly two-thirds of cases. Absence and/or non-compliance had not been responded to appropriately in half of relevant cases and in some, had not even been noticed. There were a number of service users who had had several changes of responsible officer, which will undoubtedly have exacerbated this problem.

In two-thirds of the cases inspected, the service user's individual diversity was not taken into account and responsible officers had failed to identify barriers to engagement. Only six service users were meaningfully involved in their own planning or reviewing of progress.

Absence of effective services to help with homelessness on release from prison continued to make abiding by the sentence much more difficult for some service users.

Impact and likely impact

Fewer than half of the service users in the inspection had complied with their sentence. The impact of changes in responsible officers was clearly evident from the comments of one service user:

"I did not get on with probation. I have had lots of different officers and I have not been able to bond with any of them as they kept changing."

Other service users clearly demonstrated the potential value a good working relationship:

"My mental health broke down through schizophrenia. It was all related to that. I am more inclined to go for the injections as my responsible officer has kept an eye on me. He knew my background and took my anxieties into account. He visited me at home. That was fine. It seems to have gone pretty well."

"I was to attend the Building Better Relationships programme. I thought it would be three months of how awful we were, but that was not the case. The syllabus was interactive, we could ask questions and everything was explained carefully. My responsible officer supported me to attend. Probation staff were not what I expected, I thought it would be like the job centre, but it wasn't. It was very professional and caring. I have learned a lot and I am now considering whether I can develop my skills.

My responsible officer has introduced me to Westminster Drug Project and I am being assessed as a potential peer mentor, which I am keen about. [I have] nothing but praise for her, she has been supportive and very professional."

The following table identifies the key barriers to the CRC gaining compliance of individuals with their sentence. There were no identified enablers to this work.

Barriers	
1.	Unmanageable caseloads led to a lack of contact with service users, with weak monitoring systems and limited operational and senior management oversight compounding this problem.
2.	The individual diverse needs of service users were not sufficiently taken into account.
3.	Homelessness on release from prison was a major hurdle to overcome, and was hindered by a lack of effective accommodation services.

NPS effectiveness

NPS performance was generally good, with work to encourage compliance and to enforce non-compliance carried out well.

Delivery

The number of appointments offered was sufficient for the individual's needs in most cases and absences, non-compliance or other inappropriate behaviour were responded to sufficiently in all but one case where it was necessary. Probation services had made sufficient progress in delivering the legal requirements of the order or licence in all but two cases inspected.

The work of involving and engaging service users was less consistent, although generally good. The responsible officer sufficiently identified any barriers to effective engagement in 14 out of 18 relevant cases; service users' individual diversity was sufficiently taken into account in over two-thirds of cases; and they were meaningfully involved in planning the work in 14 out of 19 relevant cases. There was less consistent evidence of involving the service user in reviews.

Good practice example: *Archie had a history of offending, in the main against his mother. He was sentenced to custody for breaching the conditions of the order restraining his contact with her. He was homeless on release from prison and the responsible officer worked hard to put him in touch with workers who would help him secure accommodation. He paid good attention to Archie's individual needs, balancing practical support with the necessity of completing offending behaviour work.*

Impact and likely impact

The value of good working relationships was clearly evident in these comments from service users:

"[My responsible officer] advised what is right and wrong. She kept me on track. She was good as gold."

"I've been on probation lots of times and normally I don't bother. But this time they don't even have to write down the appointments, I remember them in my head. I trust her and feel like I can say what is going on and they will listen. In the past it was more of them telling me stuff. Now they listen and I trust them."

"[My responsible officer] was constantly listening to me. I don't tend to open up and talk a lot but he was such a good listener that I found myself talking and talking. He took all my needs into account - and discussed all my needs however big or small. He hasn't offered false dreams. My probation officer has turned my life around. He's the only one who's got results."

Practical help was valued by service users but this was not always felt to be available. More than one service user talked about leaving prison with nothing:

"I had nothing when I got out of prison - no clothes and no place to live. My probation officer sent me to a place in London that was like a prison cell. I'd rather live on the street."

The following table identifies the key enabler to the NPS gaining the compliance of individuals with their sentence. There were no identified barriers to this work.

Enablers	
1.	Feedback from service users indicated that many responsible officers possessed effective engagement skills.

Enforcement

The relationship between CRC responsible officers and NPS enforcement officers was sometimes strained. The NPS said that breach papers were often poorly prepared and had to be returned. Data prepared by the NPS showed this to be so in about one in four cases sent for breach. Enforcement officers told us that there were similar issues with NPS responsible officers but not to the same extent. They were able to offer training to NPS staff but not to the CRC. CRC staff reported feeling at a disadvantage when dealing with NPS enforcement officers and felt that they were not always helpful.

Outcomes were sometimes compromised when the two organisations did not take a problem-solving approach. An uncompromising position was sometimes adopted, as the following example shows:

> ***Poor practice example:*** *Robert, aged 21 years old, served a custodial sentence for dealing drugs.*
>
> *On his release there was considerable police intelligence to suggest that he was continuing to deal drugs. The CRC responsible officer attempted to recall him to prison in February 2016. NOMS believed, however, that his licence was incorrect and would not act to recall him until it had been amended. The prison maintained that it was the correct licence and would not amend it.*
>
> *The situation was not resolved until Robert was recalled in August 2016 when he was arrested for a number of robberies that he had committed during the previous months while his recall was being debated. He was suspected of involving younger people in supplying drugs during that period.*

We were told by NPS enforcement officers that they had initially been discouraged from contact with CRC staff but that this had changed. Minutes from the Service Integration Group suggested that some NPS enforcement officers were confused about the supervision requirements of post-sentence supervision.

The following table identifies the key enablers and barriers to the work of the CRC and NPS working together to gain compliance of individuals with their sentence:

Enablers		Barriers	
1.	There was evidence of ongoing work to improve interface issues, which demonstrated a willingness on the part of both organisations to resolve problems through dialogue.	1.	Relationships between agencies over enforcement issues were strained.

Appendices

Appendix 1: Inspection methodology

HMI Probation's Quality & Impact programme commenced in April 2016, and has been designed to examine probation work in discrete geographical areas, equivalent to a police/Police and Crime Commissioner area, regardless of who delivers the work. We are interested in the work of both the NPS and the CRC, together with the contribution of any partners working with these organisations.

An inspection team visited the area for two full weeks. In the first week, we inspected a pre-determined number of cases (community orders, suspended sentence orders, and licences) of individuals sentenced or released from prison about nine months previously. These cases may not have been fully representative of all the eligible cases, but so far as possible we made sure that the proportions matched in terms of (i) gender, (ii) ethnicity, (iii) sentence type and (iv) office location – with minimum numbers set for (i) and (ii). Cases were also selected from the full range of risk of serious harm and likelihood of reoffending levels, and from as many responsible officers as possible. In the North of London, the sample consisted of 61 cases, 40 of which were CRC cases and 21 of which were NPS cases.

The team then returned two weeks later to follow-up issues that had emerged in the first week, and spoke with key staff, managers and partners (40 from the NPS and 37 from the CRC). We attempted to speak with those service users who provided their consent to being contacted. In this inspection, we spoke with nine service users whose cases we inspected: six from the CRC and three from the NPS.

The inspection focused on assessing how the quality of practice contributed to achieving positive outcomes for service users, and evaluating what encouraging impact had been achieved. Inspectors were mindful that current impact could provide evidence of progress towards long-term desistance. In particular, we were seeking to report on whether the work undertaken was likely to lead to reduced reoffending, the public were protected from harm and individuals had abided by their sentence.

Information on the Role of HMI Probation and Code of Practice can be found on our website:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Probation

1st Floor, Manchester Civil Justice Centre

1 Bridge Street West

Manchester, M3 3FX

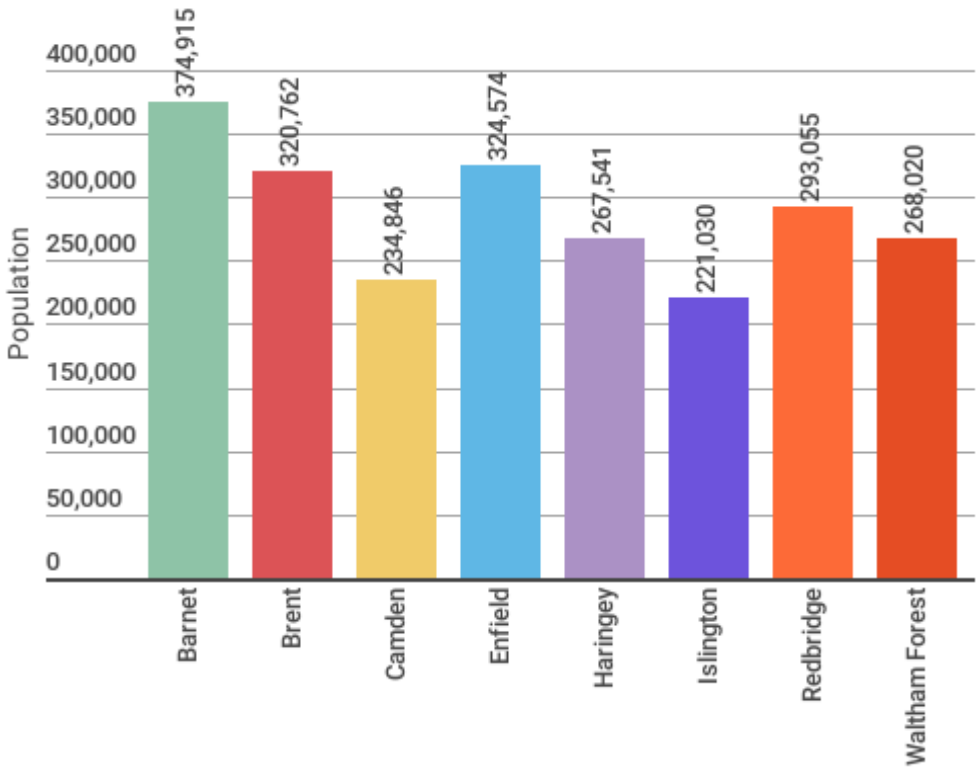
Appendix 2: Background data

This inspection covers the London boroughs of Barnet, Brent, Camden, Enfield, Haringey, Islington, Redbridge and Waltham Forest.

Population demographics

The population of London was estimated at 8,538,689 in 2014. Barnet was the most populous borough of the eight we inspected cases within.

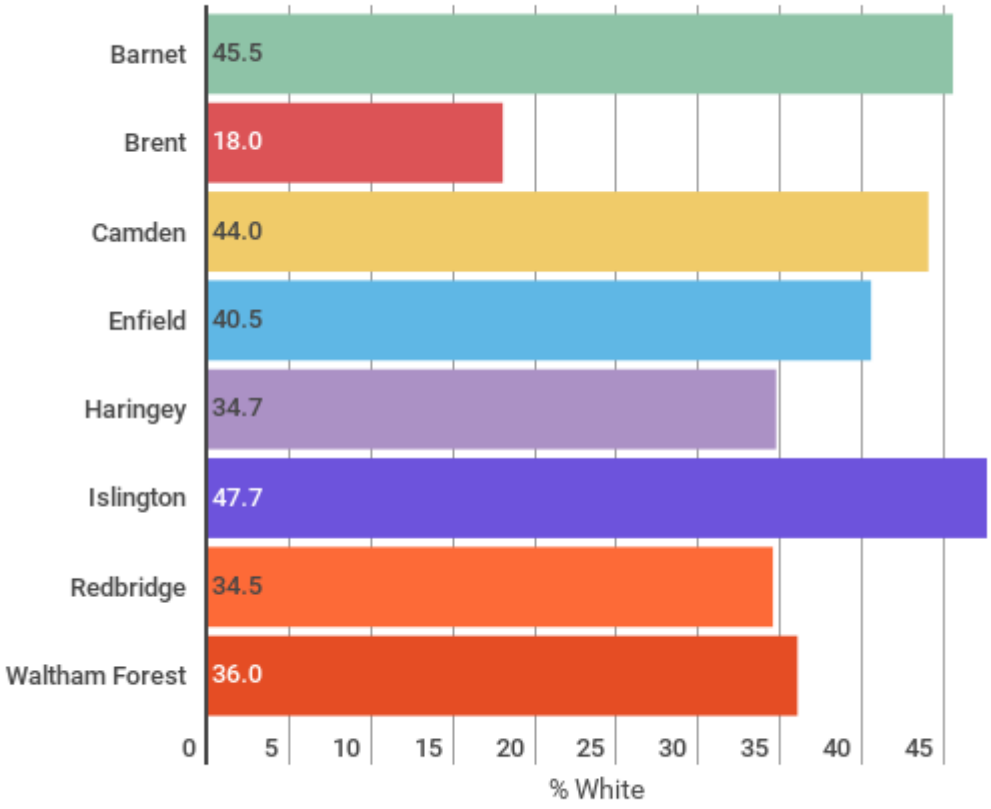
Figure 2.1: Population estimates by borough, mid-2014



Source: Office for National Statistics, June 2015

Most London boroughs have a lower proportion of white residents than the average for England & Wales (80.5%). Brent is the most ethnically diverse London borough.

Figure 2.2: Ethnicity by borough, 2011 census



Source: Office for National Statistics, December 2012

Levels of deprivation and crime

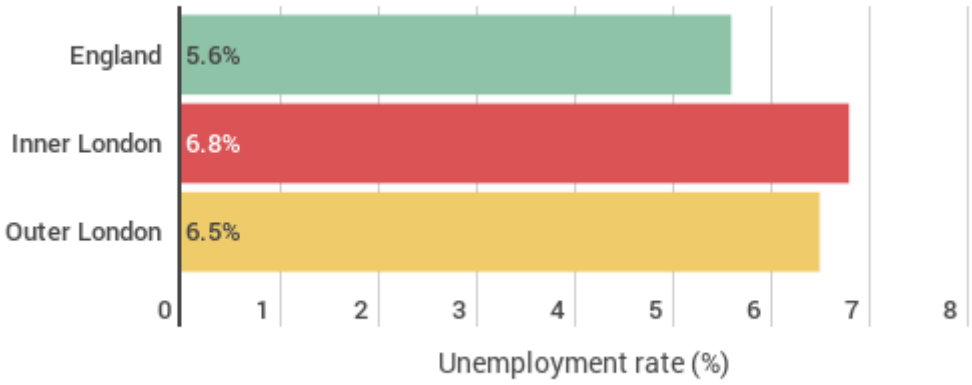
As shown by Figure 2.3, unemployment in London is slightly higher than the England average.

Inner London consists of 14 boroughs: Camden, City of London, Hackney, Hammersmith & Fulham, Haringey, Islington, Kensington & Chelsea, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Wandsworth and Westminster.

Outer London consists of 19 boroughs: Barking & Dagenham, Barnet, Bexley, Brent, Bromley, Crodyon, Ealing, Enfield, Greenwich, Harrow, Havering, Hillingdon, Hounslow, Kingston upon Thames, Merton, Redbridge, Richmond upon Thames, Sutton and Waltham Forest.

Of the London boroughs we inspected in the north of London, five are classed as outer London and three as inner London

Figure 2.3: Unemployment in London, July 2014 to June 2015



Source: Office for National Statistics, August 2015

Figure 2.4 sets out measures of deprivation

The first two measures are based on the seven domains of (i) income, (ii) employment, (iii) education, skills and training, (iv) health and disability, (v) crime, (vi) barriers to housing and services, and (vii) living environment.

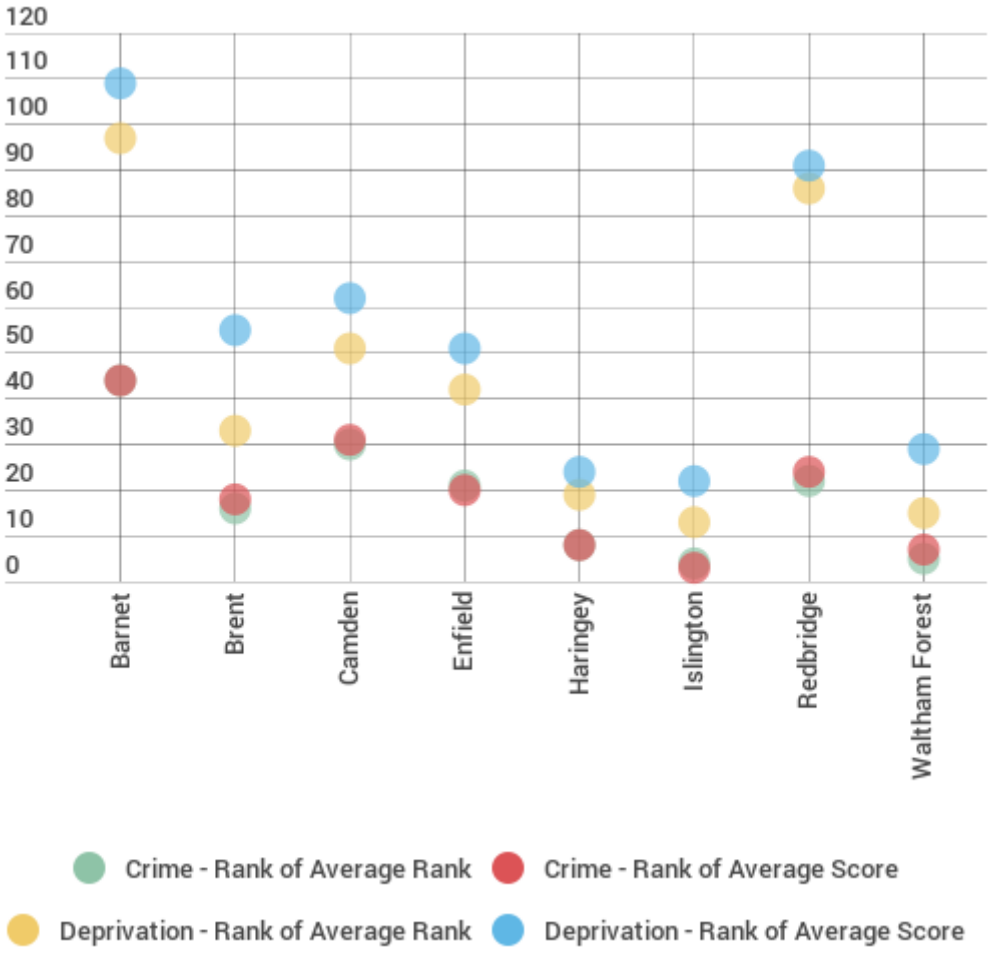
The second two measures focus on the crime domain, based upon crime rates relating to violence, burglary, theft and criminal damage.

The 'average rank' summarises the average level of deprivation across each local authority as a whole, based on the ranks of the areas in each authority. In the 'average scores', areas with a larger mix of prosperity and deprivation tend to score higher and reflect that social mix, with less averaging out.

Across all measures, the local authority with a rank of 1 is the most deprived, and the area ranked 152 is the least deprived.

Barnet and Redbridge have lower levels of general deprivation but have average levels of crime deprivation.

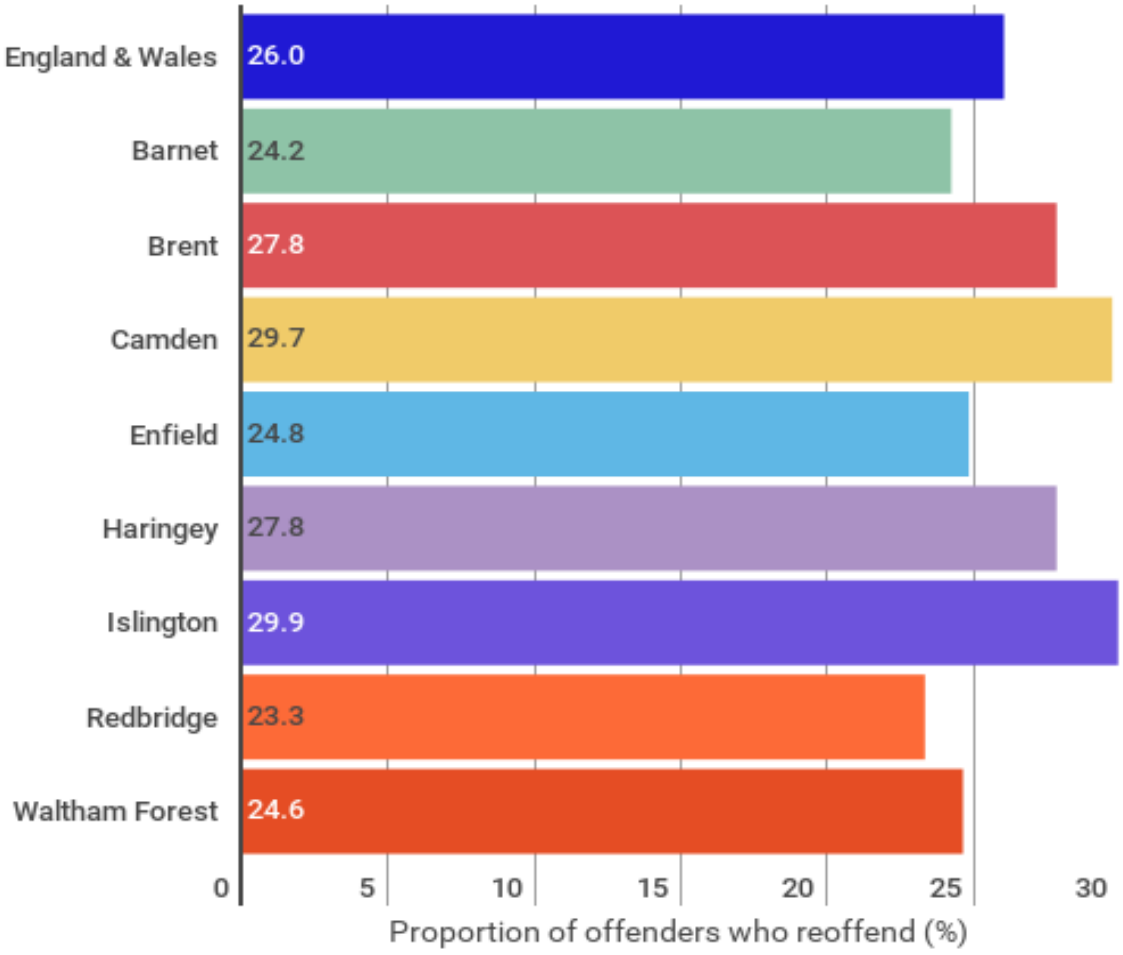
Figure 2.4: Multiple deprivation measures by local authority, 2015



Levels of reoffending

Reoffending rates for London boroughs are set out in Figure 2.5, based upon adult offenders who were released from custody, received a non-custodial conviction at court or received a caution (i.e. not just those who were released from custody) in the period July 2013 to June 2014.

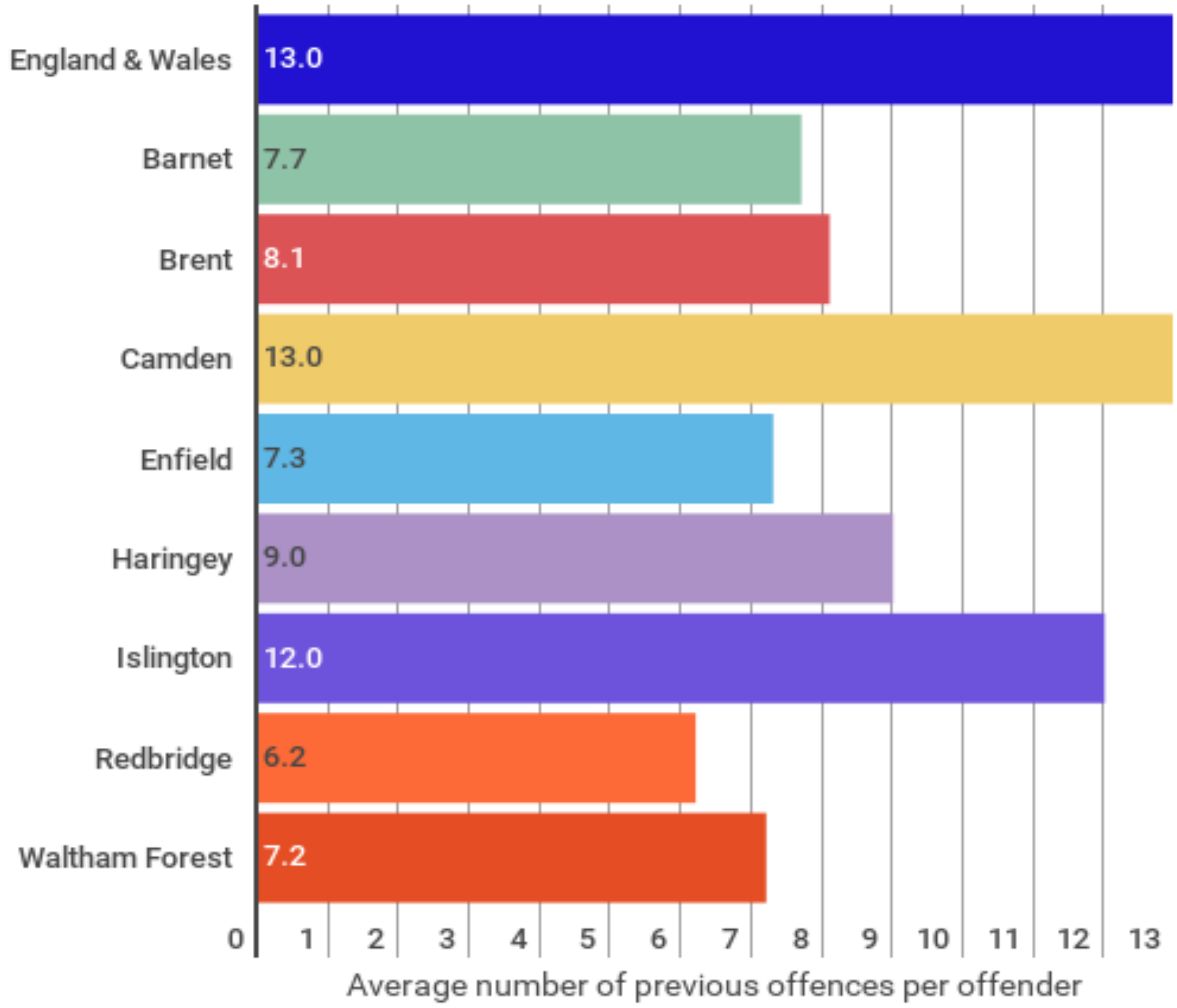
Figure 2.5: Reoffending rate by borough, July 2013 to June 2014



Source: Ministry of Justice, April 2016

There were fewer previous offences on average for the London offender cohort than for England & Wales as a whole, although this varied considerably by borough (see Figure 2.6).

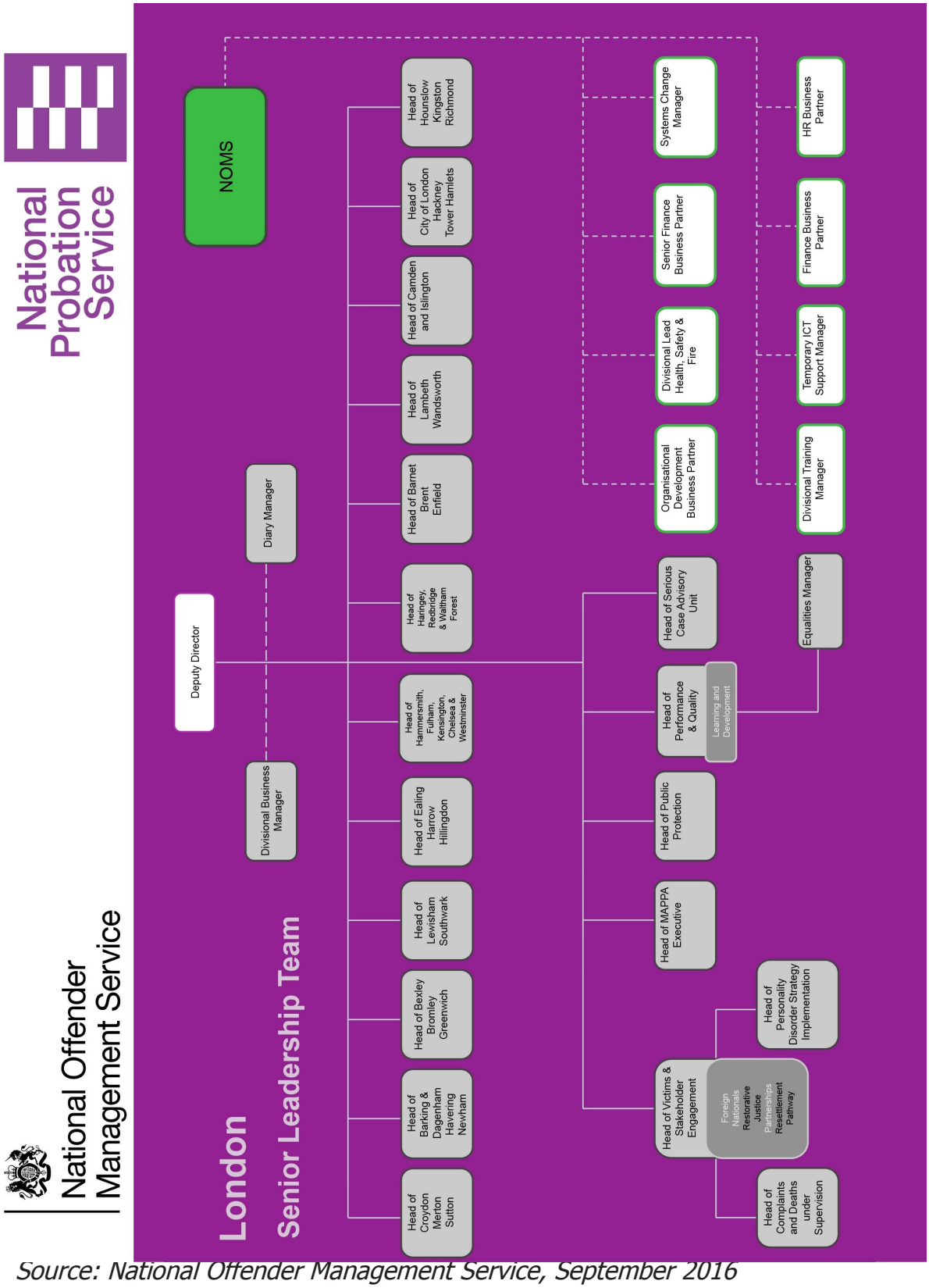
Figure 2.6: Offending histories by borough, July 2013 to June 2014



Source: Ministry of Justice, April 2016

Appendix 3: Contextual information relating to the NPS

Figure 3.1. Organogram of the senior leadership team for the London NPS division



Source: National Offender Management Service, September 2016

Appendix 4: Data analysis from inspected cases

These charts illustrate key findings from relevant practice inspection cases. These are combined figures for the area as a whole (not separate CRC and NPS figures) due to the small numbers involved. These charts show absolute numbers rather than percentages. The size of the bar chart segments provides an idea of proportion, while the number gives an idea of how large the sample was.

Figure 4.1: Reducing Reoffending

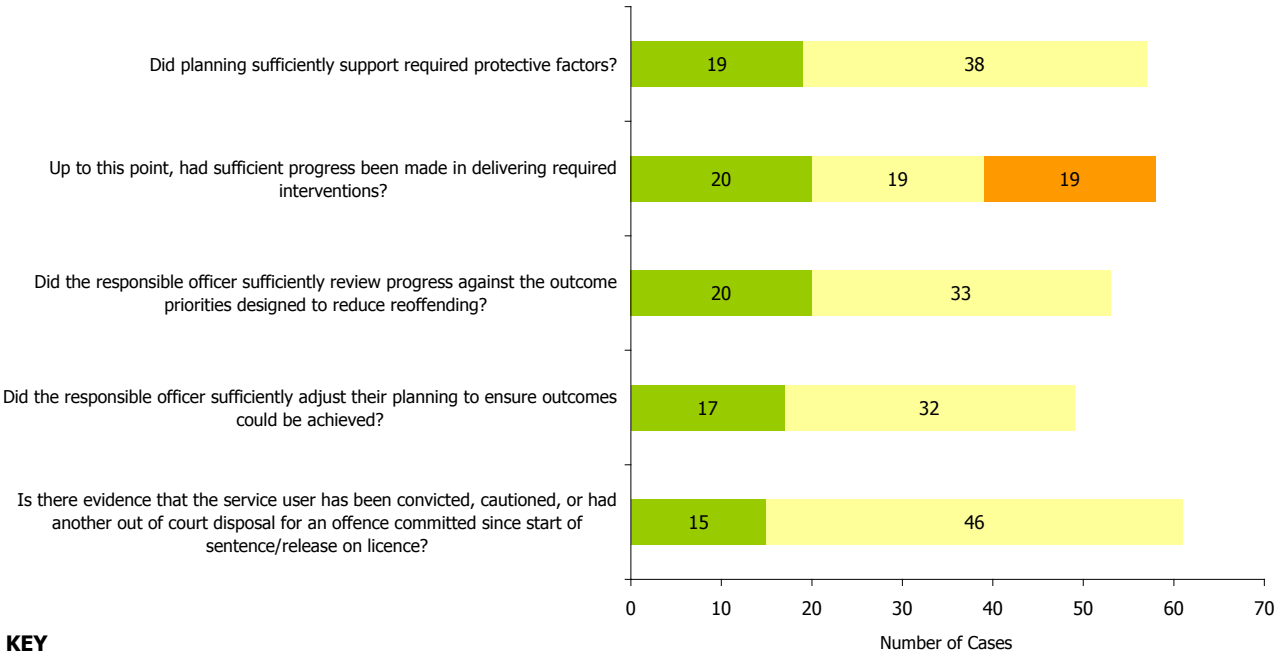


Figure 4.2: Public Protection

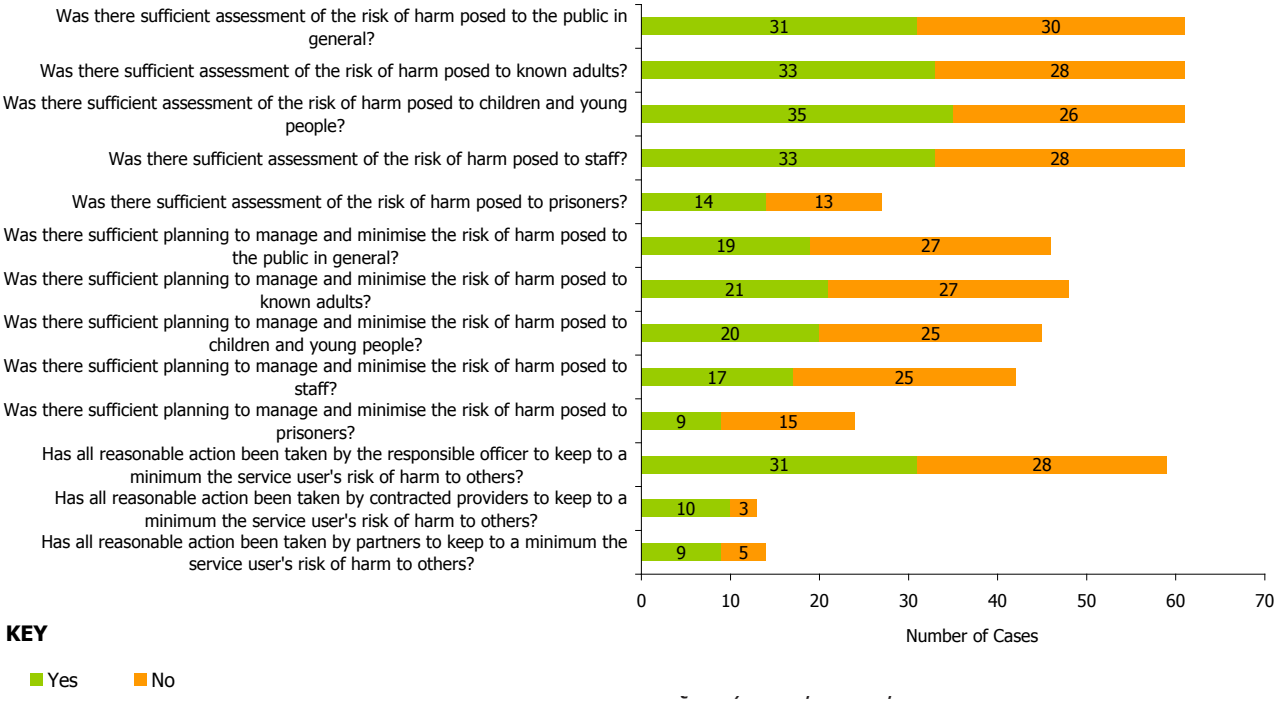


Figure 4.3: Public Protection

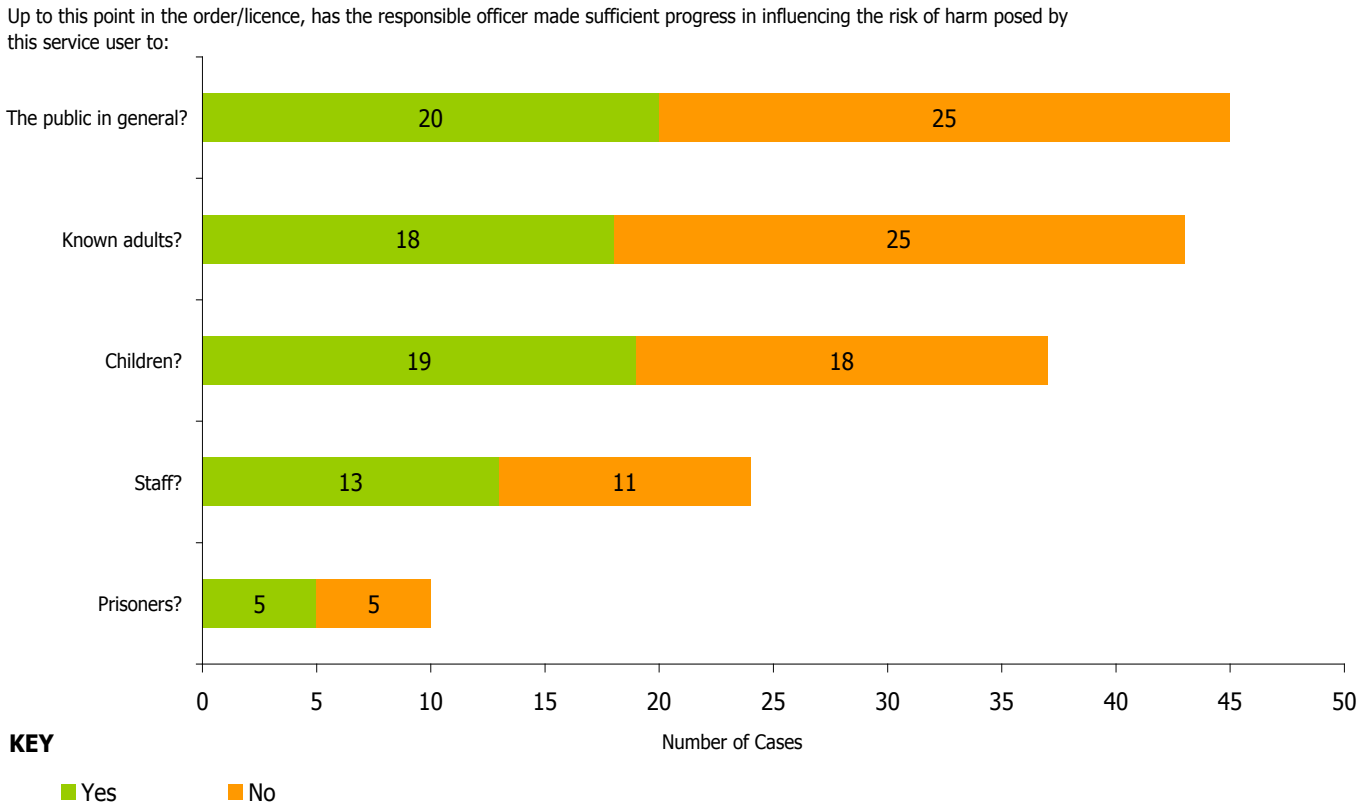
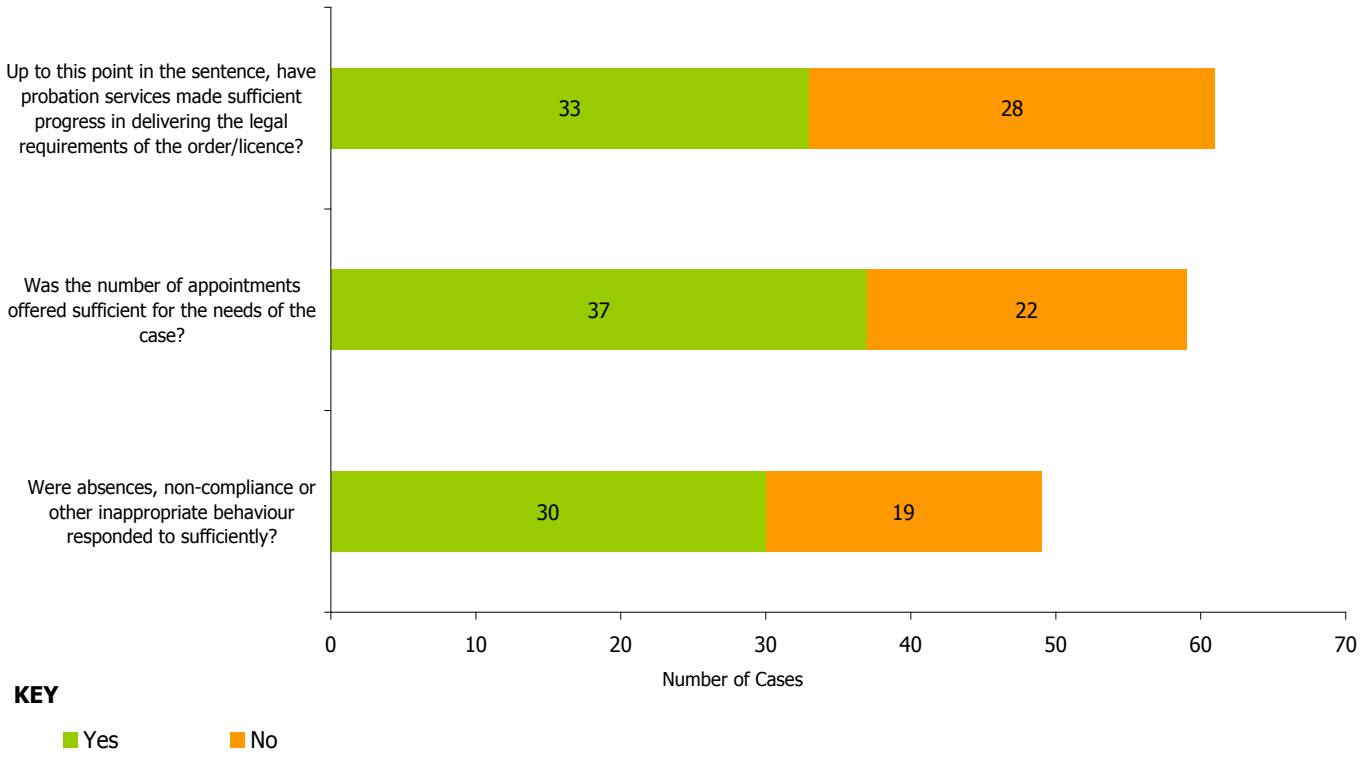


Figure 4.4: Abiding by the Sentence



Appendix 5: Glossary

Assistant Chief Officer	Senior managers with strategic or functional responsibilities
Alcohol Treatment Requirement	A requirement that a court may attach to a community order or a suspended sentence order aimed at tackling alcohol abuse
Allocation	The process by which a decision is made about whether an offender will be supervised by a CRC or the NPS
Assignment	The process by which an offender is linked to a single responsible officer, who will arrange and coordinate all the interventions to be delivered during their sentence
BBR	Building Better Relationships: a nationally accredited groupwork programme designed to reduce reoffending by adult male perpetrators of intimate partner violence
CAS	Case Allocation System: a document that needs to be completed prior to the allocation of a case to a CRC or the NPS
Cluster	A grouping of adjacent local delivery units to assist in the administration and monitoring for the NPS. For example, in London the 32 boroughs are organised into 12 clusters
CRC	Community Rehabilitation Company: 21 such companies were set up in June 2014, to manage most offenders who present a low or medium risk of serious harm
Criminal behaviour order	An order designed to tackle the most serious and persistent anti-social individuals where their behaviour has brought them before a criminal court
Desistance	The cessation of offending or other antisocial behaviour
E3	E3 stands for 'Effectiveness, Efficiency, and Excellence'. The E3 programme was created following the *Transforming Rehabilitation* programme in June 2014. The basic principle is to standardise NPS delivery, redesigning the NPS structure with six key areas of focus, including: community supervision; court services; custody; youth offending services; victim services; and approved premises
HMP	Her Majesty's Prison
IOM	Integrated Offender Management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together

LDU	Local delivery unit: an operational unit comprising of an office or offices, generally coterminous with police basic command units and local authority structures
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level 1 is ordinary agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with Levels 2 and 3, which require active multi-agency management
Multi-Agency Risk Assessment Conference	Part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/ survivors, children and the alleged perpetrator
MoJ	Ministry of Justice
nDelius	National Delius: the approved case management system used by CRCs and the NPS in England and Wales
NOMS	National Offender Management Service: the single agency responsible for both prisons and probation services
NPS	National Probation Service: a single national service which came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA
OASys	Offender Assessment System currently used in England and Wales by CRCs and the NPS to measure the risks and needs of offenders under supervision
Offender Rehabilitation Act 2014	Implemented in February 2015, applying to offences committed on or after that date, the *Offender Rehabilitation Act 2014* is the Act of Parliament that accompanies the *Transforming Rehabilitation* programme
Partners	Partners include statutory and non-statutory organisations, working with the service user/offender through a partnership agreement with the CRC or NPS
Providers	Providers deliver a service or input commissioned by and provided under contract to the CRC or NPS. This includes the staff and services provided under the contract, even when they are integrated or located within the CRC or NPS
PSR	Pre-sentence report: this refers to any report prepared for a court, whether delivered orally or in a written format

PO	Probation officer: this is the term for a qualified responsible officer who has undertaken a higher education-based course for two years. The name of the qualification and content of the training varies depending on when it was undertaken. They manage more complex cases
PSO	Probation services officer: this is the term for a responsible officer who was originally recruited with no probation qualification. They may access locally determined training to qualify as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases depending on their level of training and experience. Some PSOs work within the court setting, where their duties include the writing of pre-sentence reports
Rate card	Offending behaviour services offered by the CRC for use by the NPS with their service users, for example, accredited programmes
RAR	Rehabilitation activity requirement: from February 2015, when the *Offender Rehabilitation Act 2014* was implemented, courts can specify a number of RAR days within an order; it is for probation services to decide on the precise work to be done during the RAR days awarded
Responsible officer	The term user for the officer (previously entitled 'offender manager') who holds lead responsibility for managing a case
RSR	Risk of Serious Recidivism: an actuarial calculation of the likelihood of the offender being convicted of a serious sexual or violent offence; this calculation was introduced in June 2014 as a required process in the implementation of *Transforming Rehabilitation*
SPO	Senior probation officer: first line manager
Service Integration Group	A meeting between the CRC and the NPS focused on the interface between the organisations
Supply chain	Providers of services commissioned by the CRC
Suspended Sentence Order	A custodial sentence that is suspended and carried out in the community
Third sector	The third sector includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives

Through the Gate	Through the Gate services are designed to help those sentenced to more than one day in prison to settle back into the community upon release and receive rehabilitation support so they can turn their lives around
Transforming Rehabilitation	The government's programme for how offenders are managed in England and Wales from June 2014

Appendix 6: Acknowledgements

We would like to thank all those who took part in this inspection; without their cooperation, the inspection would not have been possible.

We would like, in particular, to thank the senior managers and their personal/executive assistants for facilitating the inspection and making the necessary arrangements for the fieldwork weeks.

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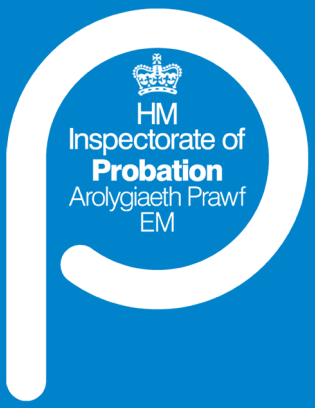
Report Editor	Helen Rinaldi, *Assistant Chief Inspector*



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